SUBMISSION DATE 28th NOVEMBER 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>East Riding of Yorkshire Council (ERYC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Commissioning Groups</td>
<td>NHS East Riding of Yorkshire Clinical Commissioning Group (ERYCCG)</td>
</tr>
<tr>
<td>Boundary Differences</td>
<td>NHS Vale of York Clinical Commissioning Group (VoYCCG)</td>
</tr>
<tr>
<td></td>
<td>The Pocklington Group Practice, and its main catchment population, sits within the ERYC boundaries but is aligned with the VoYCCG.</td>
</tr>
<tr>
<td></td>
<td>The VoYCCG has been engaged in the development of the East Riding Better Care Fund (BCF) Plan. They are also members of both the Health and Wellbeing Board and the BCF Programme Board, who are responsible for the governance of this programme.</td>
</tr>
<tr>
<td></td>
<td>There are also a number of East Riding of Yorkshire residents who are registered with General Practices that are not part of either ERYCCG or VoYCCG and, similarly, a</td>
</tr>
</tbody>
</table>
number of residents of other Local Authorities; namely Hull City Council, North Lincolnshire Council, North Yorkshire Council; who are registered with Practices who are members of the two BCF allied CCGs.

For this NHS-cross boundary population, work is underway to assess the relative impact of the NHS patient flows to ensure the plan reflects the differential impact of different CCGs commissioning decisions. At present it is being assumed that the differences balance out so that the whole of ERYCCG’s registered population - and the agreed parts of VoYCCG’s registered population - are taken as a whole and as being representative of the whole registered population.

| Date agreed at Health and Wellbeing Board: | This submission- 28/11/2014  
Third submission – 18/09/2014  
Second submission – 02/04/2014  
First submission – 11/02/2014 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date submitted:</td>
<td>28/11/2014</td>
</tr>
</tbody>
</table>

Minimum required value of BCF pooled budget: 2014/15 £ 8.635m (Value of current NHS Transfer via s251. No pooled budget in 2014/15)

<table>
<thead>
<tr>
<th>2015/16</th>
<th>£22.478m</th>
</tr>
</thead>
</table>

Total agreed value of pooled budget: 2014/15 £ 8.635m (Value of current NHS Transfer via s251. No pooled budget in 2014/15)

| 2015/16       | £22.478m |
### b) Authorisation and sign off

<table>
<thead>
<tr>
<th>Signed on behalf of the Clinical Commissioning Group</th>
<th>NHS East Riding of Yorkshire CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>By</td>
<td>[Signature]</td>
</tr>
<tr>
<td>Position</td>
<td>Karen Ellis</td>
</tr>
<tr>
<td>Date</td>
<td>28(^{\text{th}}) November 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed on behalf of the Clinical Commissioning Group</th>
<th>NHS Vale of York CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>By</td>
<td>Not signed for this refresh</td>
</tr>
<tr>
<td>Position</td>
<td>Chief Clinical Officer</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed on behalf of the Council</th>
<th>East Riding of Yorkshire Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>By</td>
<td>[Signature]</td>
</tr>
<tr>
<td>Position</td>
<td>Rosy Pope</td>
</tr>
<tr>
<td>Date</td>
<td>28(^{\text{th}}) November 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed on behalf of the Health and Wellbeing Board</th>
<th>East Riding Health and Wellbeing Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Chair of Health and Wellbeing Board</td>
<td>Not signed for this refresh</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
### Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

<table>
<thead>
<tr>
<th>Document or information title</th>
<th>Synopsis and links</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Pioneering Excellence for Older People’ Pioneer Application - June 2013</td>
<td>The original vision for integrated care and support for older people in Hull and East Riding. The application, submitted by the ERYC, Hull City Council, ERYCCG and Hull Clinical Commissioning Group, highlights the commitment from local partners to embed person-centred care in all services.</td>
</tr>
<tr>
<td>Joint Health and Wellbeing Strategy (JHWS) – 2013</td>
<td>The BCF Plan is aligned with the JHWS strategy, particularly around the aims of reducing preventable admissions and achieving healthy independent ageing.</td>
</tr>
<tr>
<td>East Riding of Yorkshire CCG Strategic Plan 2014 – 2019</td>
<td>Sets out the CCG’s overarching strategic plan for the next 5 years.</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>These documents and resource website link in to the development of the Joint Health and Wellbeing Strategy, ERYCCG’s Strategic Plan and the BCF Plan with a particular focus on prevention, supporting independent living for older people and reducing avoidable admissions to acute hospitals.</td>
</tr>
</tbody>
</table>
| Joint Adult Commissioning Strategy - 2012 | The key objectives highlighted in this strategy, developed by ERYC Adult Services and the ERYCCG, are fully aligned with the development of integrated services within the BCF programme. In summary they are:  
- prevention and staying healthy;  
- urgent care and recovery;  
- continuing support and managing long term conditions. |
| Older People Strategy – 2010-2015 | The key objectives highlighted in this strategy, targeted at people aged 50 years and over in the East Riding, are aligned to the development of integrated services within the BCF programme. In summary they are:  
- improved health and emotional wellbeing;  
- increased independence, choice and control;  
- increased community involvement and reduced isolation. |
<table>
<thead>
<tr>
<th>Carers Strategy – 2010-2015</th>
<th>The BCF Plan is linked in to the Carers Strategy with a particular focus on access to timely information and advice, access to integrated and personalised services and support to help carers stay mentally and physically well.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems Resilience Plan – 2014-2015</td>
<td>This Systems Resilience Plan (SRP) outlines the systems and processes that have been put in place to enable both Hull and East Riding of Yorkshire health and social care systems to work together to deliver an integrated health and social care system, providing seamless care and care pathways whilst recognising the diversity inherit in the different populations and the different health and social care parameters across our communities. The SRP shares the vision of the BCF in that two of its key focus areas are the delivery of integrated care and the promotion of self-care initiatives.</td>
</tr>
</tbody>
</table>
2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20. In building our vision for health and social care we have utilised a range of sources to identify the needs of our resident population.

**Joint Strategic Needs Assessment**

The 2010/11 Joint Strategic Needs Assessment for the East Riding of Yorkshire has identified the following key priority areas for health and social care commissioners:

<table>
<thead>
<tr>
<th>Addressing the health and care needs of the ageing population (Quality of Life)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opportunities through transformation of the service model to support the management of Long Term Conditions and promote self-care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Addressing inequalities in health and care outcomes (Quantity of Life)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opportunities through preventing ill health progression by minimising deterioration of existing conditions</td>
</tr>
</tbody>
</table>

| Addressing the mental and physical health and wellbeing of Children and Young People |

The main points drawn out in this year’s update of the JSNA, which resulted in the identified key priority areas, highlighted above, are as follows:

The East Riding of Yorkshire has a higher than average percentage of the population aged over 65 which equates to 20.6% (approximately 66,000 people), compared with the England average of 15.6%. These result in higher levels of age related challenges including Long Term Conditions such as, general frailty associated with the ageing process and deteriorating cognitive functions (Dementia).

### Projected health needs for East Riding CCG area 2011-2030 (based on national estimates of population change)

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 and over</td>
<td>16%</td>
<td>30%</td>
<td>45%</td>
<td>62%</td>
</tr>
<tr>
<td>Aged 65 and over with a limiting long-term illness</td>
<td>16%</td>
<td>31%</td>
<td>48%</td>
<td>67%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to have a longstanding health condition caused by a heart attack</td>
<td>16%</td>
<td>30%</td>
<td>47%</td>
<td>65%</td>
</tr>
<tr>
<td>Aged 18 and over predicted to have a longstanding health condition caused by a stroke</td>
<td>12%</td>
<td>24%</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to have a longstanding health condition caused by bronchitis and emphysema</td>
<td>16%</td>
<td>31%</td>
<td>46%</td>
<td>64%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to have dementia</td>
<td>14%</td>
<td>37%</td>
<td>65%</td>
<td>99%</td>
</tr>
<tr>
<td>Aged 18 and over predicted to have diabetes</td>
<td>9%</td>
<td>19%</td>
<td>27%</td>
<td>37%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to have depression</td>
<td>16%</td>
<td>30%</td>
<td>44%</td>
<td>62%</td>
</tr>
<tr>
<td>People aged 75 and over predicted to have a moderate or severe visual impairment</td>
<td>14%</td>
<td>35%</td>
<td>70%</td>
<td>91%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to have a bladder problem at least once a week</td>
<td>15%</td>
<td>31%</td>
<td>49%</td>
<td>69%</td>
</tr>
<tr>
<td>Aged 18 and over predicted to have a moderate or severe learning disability</td>
<td>3%</td>
<td>8%</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td>Aged 18 and over predicted to have a learning disability</td>
<td>4%</td>
<td>9%</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>Aged 65 and over predicted to be admitted to hospital as a result of falls</td>
<td>14%</td>
<td>34%</td>
<td>62%</td>
<td>82%</td>
</tr>
<tr>
<td>Number of people aged 65 and over helped to live independently</td>
<td>16%</td>
<td>30%</td>
<td>45%</td>
<td>62%</td>
</tr>
</tbody>
</table>
The above table refers to specific work undertaken by East Riding of Yorkshire CCG, one of the CCG members of the East Riding of Yorkshire Health and Wellbeing Board and illustrates the distribution of disease across a range of sub regions across the East Riding of Yorkshire.

NB: CHERY is the acronym for the Beverley and Driffield locality and GHWW relates to the Goole, Howdenshire and West Wolds locality.

Poor management of chronic diseases leads to wasteful use of high intensity resources:

- 80% of bed days in hospitals are currently attributable to patients admitted as an emergency admission.
- many of these admissions are preventable; by strengthening care in the community and general practice many patients may never need hospital treatment.
- of the eleven leading causes of hospital bed use in the UK, eight are due to conditions which if we strengthened community care could lead to a fall in
admissions. 50% of bed day use is accounted for by only 2.7% of all medical conditions, most of which are chronic diseases. (Source: HES data 2002)

The Government’s 2012 Alcohol Strategy\(^1\) has used a variety of data sources to estimate that in a community of 100,000 people, 2,000 will be admitted to hospital with an alcohol-related condition each year. This would equate to just over 6,000 people in the East Riding where services have been developed at different levels to include Prevention, Brief Intervention and Treatment in line with the Government’s new Alcohol strategy.


In the context of an ageing population the increased number of people who have one or more long-term condition drives the need for patients and service user’s to cut across multiple health and social care services. This identifies the concern that health and social care services cannot be delivered effectively or efficiently through episodic care in acute hospital services. Existing research suggests that there are a range of factors to better enable independent living and improve the quality of life and wellbeing for older people. At the core of these findings is the importance of prevention and the promotion of social inclusion.

Increasing demand and financial pressures means there is a need to focus on prevention (primary, secondary, and tertiary), reducing the demand for services and making the most efficient and effective use of health and social care resources.

By 2018, the number of people nationally with three or more long term conditions is expected to rise to 2.9 million; in 2008 this figure stood at 1.9 million (Department of Health 2012). Prevention remains the key intervention to curb this rise in health and social care needs, for example supporting people to change behaviours such as smoking, alcohol misuse, sedentary life, unhealthy diet. Furthermore, tailoring interventions to the conditions, for example for conditions such as diabetes, structured patient education may be beneficial, while conditions such as depression may require behavioural interventions.

The relative affluence associated with a number of the market towns and villages in the East Riding masks higher levels of deprivation, and correspondingly poorer lifestyles/health in a number of our coastal resorts and larger urban conurbations. This results in inequalities in health outcomes with a demonstrable difference in life expectancy for both men and women between those wards classified as prosperous and those with marked levels of deprivation.

Whilst the age profile demonstrates a need to support our older population to experience healthy, independent aging, we are aware of our responsibilities to our younger population groups especially our vulnerable children for example with respect to obesity and childhood long term conditions; asthma, epilepsy and diabetes.

Whilst the majority of electoral wards now have levels of childhood obesity lower than England average, childhood obesity remains an area of focus for us. The National Child Measurement Scheme has reached the point whereby the children in Year 6 were part of
the programme in Reception and early indication is that childhood obesity in the East Riding of Yorkshire might have levelled off. However, it is still high in certain areas. Specific programmes we have introduced include:

- ‘Young live well’ which is an individualised programme of exercise and lifestyle management aimed at pre-teens and teens, including their families to support the individual and their family to change their behaviour patterns for life.
- School focused programmes around healthy eating, exercise and general lifestyle decisions.

Childhood long term conditions; asthma, epilepsy and diabetes; impact upon a relatively small number of our population. But for those who do have them, the impact lasts into their adult years and developing self-management skills within our children means that we will have adults in the future with the confidence to self-manage their conditions. Every GP Practice undertakes the monitoring and support of children with asthma and a revised programme to review, and support the development of, good inhaler technique is being developed to recognise the rapid change in asthma drug delivery systems which require different techniques. For our younger people with diabetes we are looking, from a health perspective, to support the delivery of the diabetes best practice tariff and are, from a wider perspective, increasing the skills within schools to support children and young people with long term conditions to self-manage and reduce the feelings of being different, often experienced by adolescents.

**Joint Health and Wellbeing Strategy**

The Joint Health and Wellbeing Strategy (JHWS) and the Clinical Commissioning Group’s Strategic Plans are based upon the identified local needs arising from the JSNA and are as articulated above in the JSNA section. The JHWS and the East Riding of Yorkshire Clinical Commissioning Group’s (CCG) Strategic Plan share the same strategic aims. These strategic aims have been adopted by the BCF. The work programme underpinning the delivery of the JHWS is mirrored in the CCG’s strategic plan. Those work programmes have been reviewed against the aspirations of the BCF and those work programmes which are focused on delivering the expected outcomes of the BCF Plan have been incorporated within the BCF plan to add pace and direction to the programmes. Similarly opportunities identified through the BCF work which does not fit the BCF remit has been identified back to wider organisations for inclusion in wider organisational delivery programmes.

**Patient and Public Engagement**

As a health and care community we are committed to the co-production of plans and services. A wide range of involvement / engagement events have been held and used to inform the development of the strategic vision as well as the underlying work programme.

Services need to be redesigned, to work with local residents in co-producing health and wellbeing in their homes and communities, supported by integrated health and social care services that are designed to respond to the changing multi-faceted needs of an aging population.

As a health and care community we are committed to the principles and practice of co-design of integrated services through engagement and involvement of East Riding of
Yorkshire residents this is reflected in our objectives and in the plans, services and outcomes generated.
A wide range of involvement/engagement events have been held and used to inform the development of the strategic vision as well as the underlying work programme.

**Insight polling** We have sought the views through a telephone and website poll of 1,150 local residents who are demographically representative of the East Riding about what health and social care might look like in the future and to help us to understand what matters to local people as we plan services. Feedback from this survey indicated that General Practice is central to future service planning as it is regarded as a trusted, local and reliable point of contact for health care needs:

- **86%** chose GP practice services as the top service to be available at the weekend;
- **77%** chose GP practice services as their second preferred alternative to A&E admission (after minor injury services which was the first choice of 83% of respondents);
- **68%** chose the GP practice as the preferred location for community hub services;
- **60%** chose the GP practice as the preferred option for receiving information to stay healthy;
- **55%** chose the GP practice as the most preferred option as an alternative to reduce hospital admission or visits;
- **55%** chose the GP as the preferred way to become actively involved in discussions about end of life care at an early stage;
- **44%** chose the GP practice as the preferred option for providing support to older people to help them maintain independence and remain healthy at home. This was followed closely by social care and voluntary service support such as befriending and meals on wheels (40%).

A preference was also often expressed for voice based contact (e.g. telephone and Skype) as a method of communication about healthcare services:

- **80%** chose voice based contact as the preferred alternative to a face to face follow up after a hospital procedure;
- **71%** chose voice based contact as the most preferred option for a Single Point of Access to services;
- **44%** chose a telephone helpline as the preferred option for providing support to older people to help them maintain independence and remain healthy at home, making this the second most popular choice.

**Urgent care events**

We held two events to listen to patient stories and seek the views of patients and their family/carers about what currently works well and what doesn't work so well with unplanned care services.

Some of the *major themes* that have been highlighted as valuable by our communities in response to this engagement activity are:

- quality and patient centred care;
- accessibility in the method used to contact services (such as a single point of access);
- accessibility in terms of where services are delivered, using alternative providers
and facilities to keep things within local communities;

- flexibility in terms of when services are delivered to fit in with busy modern lifestyles;
- services to promote patient independence and preventative services to encourage healthier lifestyles;
- services working in partnership to deliver care seamlessly;
- being inclusive of groups with alternative or diverse needs such as migrant communities.

**Vision**

East Riding Health and Wellbeing Board, is focused upon delivering Better Care, more locally, within budget through transformation and integration. The underlying premise is that everyone needs to do something different, including patients, carers, clinicians, wider public, healthcare professionals and social care professionals; to improve our resident population’s health and wellbeing through improved, integrated health and social care.

The health needs of our local residents have been, and continue to be, well demonstrated in the Joint Strategic Needs Assessment as evidenced above. We know that we face a significant challenge to meet the needs of our diverse population within our available resources.

Our strategic objectives have been derived from the Joint Strategic Needs Assessment (JSNA) and have been agreed jointly by the Health and Wellbeing Board and both the ERYCCG and VoYCCG as part of the work we conducted together in 2012/13 to:

i) support our patients and population to achieve healthy independent ageing.
ii) reduce health inequalities across the East Riding of Yorkshire.
iii) improve the mental and physical health and wellbeing of children and young people.

Through the work we have been conducting over the past year and our engagement with patients, the public (as illustrated above) and our stakeholders (primary, community, secondary care providers, Health and Wellbeing Board, Health Overview and Scrutiny Committee and other partner organisations) we have derived – together – a number of principles which we want our services to deliver. These principles provide a framework for developing the health and care system. As a combined health and care economy our vision is to deliver a system where:

i) individuals take greater ownership of their own health and wellbeing;
ii) services are, in the main, delivered locally in the community;
iii) there is integration of health and social care services through locality focused service delivery hubs; and that
iv) the remit for hospital based services is clear and reflects where they can add value and expertise.

b) What difference will this make to patient and service user outcomes?

We are looking at making a difference across a range of areas and linking with the service/system redesign programmes of the involved organisations that fall outside of the BCF Plan.
The differences range for the practical service changes through to more technical system enablers. From short term impacts to longer term cultural changes. All of these aspects are addressed below.

For the practical service change the difference is best illustrated through the words of a patient and for this we are using, an individual called Gladys.

Gladys suffers from Chronic Obstructive Pulmonary Disease and is developing general signs of frailty. Recently she started to feel more unwell and her family dialled 999. The ambulance came and took her to her local A&E where she was observed for a couple of hours. After this time she was moved to the Acute Assessment Unit where she remained, again under observation, for a few more hours. She was then admitted to one of the elderly medical wards where she remained for 4 days before she was identified as fit for discharge. Assessment then started regarding her discharge and she had to wait a further week for physiotherapy assessment. By this time she was starting to show signs of confusion and was becoming more dependent upon staff for activities of daily living. Gladys, her family and the nursing staff, were becoming more concerned about her ability to self-care at home. Gladys started considering care home options for after she was discharged.

This situation did not support Gladys in maintaining her confidence in, and ability to, self-care and deteriorated her level of frailty due to the prolonged stay in hospital. The range of pathway and service changes that are described in Annex 1 are designed to minimise clinically unnecessary stays in hospital and support Gladys to maintain her skills to self-care after her illness.

What we are anticipating is that in two years’ time when our system transformation is complete if Gladys became ill again she would experience a different type of care. She would have a personal care plan in place which offers her peace of mind. If she requires additional support in the future she can access this through a single point of contact to services using the dedicated telephone number. She will receive contact from the intensive support team, including both health and social care professionals, within two hours who will plan her health and social care to support her to stay at home if clinically appropriate If she needs to be reviewed by a Consultant this will be at a rapid access clinic that will have access to the diagnostic tests she may need. This holistic and person centred approach to health and social care demonstrates the effectiveness of a more collaborative way of working.
Gladys’ experience of care in 5 years

Last year, after a small operation, Gladys didn’t go back to the hospital for follow-up. The Doctor who operated on her rang her and her carer to check her progress.

When Gladys and her carer identified that her Chronic Obstructive Pulmonary Disorder was getting worse they rang the number she had been given in her Personal Care Plan. The Community Urgent Response Support Team came out and assessed her at home within 2 hours of the call and put in place a health and social care package to treat her at home and supported her whilst she was recovering.

Gladys has just reviewed her personalised care plan (PCP) with her named care coordinator to make sure it is up to date. At the same time it was checked that Gladys, and her carer, had the number for the single point of access.

Gladys feels in control and listened to. She feels she is getting the care she needs.

Gladys knows that if she needs hospital expertise she will be admitted to the frailty unit for diagnosis and tests as required and discharged with the support she needs as soon as she is ready so she can maintain her independence for as long as possible.

Gladys’ carers, from both health and social care, knew that they could access all the relevant information they needed in a single electronic document reducing duplication and improving record keeping.

Gladys was please to find out she could have all her diagnostic tests she needed and have her routine reviews in a local community facility.

Gladys feels in control and listened to. She feels she is getting the care she needs.
Overall Changes

(i) Individuals take greater ownership of their own health and wellbeing through an increased emphasis on prevention, self-care and responsibility

There will be an increased emphasis on prevention and longer term social and cultural change. Health, Social Care and Public Health will be supporting this by providing individuals with the confidence and knowledge to take responsibility of their own health. The aim is to reduce the growth in ill health, especially the development of long term conditions, in our younger population whilst recognising that one of the impacts of aging is the development of poorer health. Additionally we will be supporting a culture change whereby individuals try to manage their own minor ailments or health challenges without recourse to formal/traditional health or social care intervention. For those that do have a long term condition or a social care need they will be supported, wherever possible, to take ownership of their condition and work with health and social care providers to maintain their level of health at an optimum.

(ii) Services are, in the main, delivered locally in the community (through primary and community services)

Wherever possible services will be delivered in a community setting close to the patients home location or work if they so choose. Wherever practical, services will be delivered from a locality hub, which may be a single venue or a network of venues that work together, to deliver a comprehensive service to the local population. The services will also cross physical and mental health and social care and/or support, ensuring that all aspects of an individual's social and health care have equitable focus and the differing aspects are recognised and managed.

(iii) Integration of health and social care services through locality focused service delivery hubs

Individuals receiving care delivered in a community setting will have seen a reduction in organisational boundaries and barriers. General Practice will become the system leaders providing a leadership and a focal point for the services to their patients. Social and health care services, including the voluntary, private and charitable sectors, will either deliver integrated services or, where this is not feasible, will work in collaboration to ensure a robust, integrated health and social care service which meets the needs of their local population with a consistent offer of services and service availability across the whole of the East Riding. There will be a comprehensive 24/7 service, designed to reflect and support the differing needs for unplanned care support across the different segments of the population.

A model of integrated holistic assessment and service delivery will be evolving with differing providers of social and health care working together to minimise duplication and utilise each other’s expertise more effectively. There are currently a number of approaches to the development of pilot hub projects within the East Riding which include an ambulatory care rapid response service in the Goole, Howden and West Wolds area and a single point of access/education and self-care, which takes a holistic view of health and social care needs for residents in the Pocklington area.

Outreach services, including Consultant-led clinics and diagnostic services, will be provided either as an outreach of a local acute hospital or by a community provider...
working in collaboration with an acute provider to deliver an integrated care pathway across community and acute sectors.

(iv) The remit for hospital based services is clear and reflects where they can add value and expertise

Local acute hospitals will see a change in focus. They will have an increasing number of complex, ill patients who require their specialist support and who will remain in a hospital setting whilst they can clinically benefit from that setting. Individuals who are less complex and can be managed within a community setting will be cared for in that setting with input and advice from Consultants, as required, supporting the delivery of healthcare in the community.

Once the patient has reached clinical stability and is fit for transfer into a community setting this will occur quickly with the Consultants being able to follow up and support individuals, as required, via telehealth as well as via community based clinics. Discharge planning will begin at admission and be co-ordinated with community teams as early as possible in the process. Therapy and social care assessments will be at home or in a community setting, where appropriate, to reduce unnecessarily extended stays in hospital waiting for this type of assessment. The development of personal health budgets will contribute to supporting a person’s identified health and wellbeing needs, through a process of person-centred planning. Personal health budgets enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive. This, combined with existing personal budgets within Adult Social Care, will enable the development of a truly holistic approach to health and social care support.

There will be a change in how many beds are available within a hospital and how they are used. Surgical beds will start to reduce as patients are treated in an outpatient or day care setting more regularly and, for those who do need to stay in hospital, this stay will be minimised with a focus on getting the patient up and about and back home as soon as clinically and socially able. Emergency beds will also reduce but there will be a growth in ambulatory / short stay assessment facilities where individuals are assessed by a senior clinician, investigated and a treatment plan developed for delivery in a home setting. Where clinically necessary stays in hospital will be kept to the level needed to ensure that the expert, specialist care has been provided to optimise patient recovery before being discharged for rehabilitation and reablement in the community.

Nationally, a range of outcome ambitions have been identified; the impact we intend to make on these are identified in the table overleaf:
<table>
<thead>
<tr>
<th>NATIONAL OUTCOMES AMBITION CCG</th>
<th>THE IMPACT WE WILL MAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Securing additional years of life for the people of England with treatable mental and physical health conditions</td>
<td>Reduce the years of life lost for patients who would have prematurely died from causes that are amenable to healthcare on average by 2.3 years by 2018/19</td>
</tr>
<tr>
<td>Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions</td>
<td>Increase the quality of life reported by patients with a Long Term Condition by 2.3% by 2018/19</td>
</tr>
<tr>
<td>Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital</td>
<td>Reduce the number of days in hospital from unnecessary delays by 220 days p.a. in 2014/15</td>
</tr>
<tr>
<td>Increasing the proportion of older people living independently at home following discharge from hospital</td>
<td>Reduce the number of permanent admissions needed to care homes for over 65’s to 690 per 100,000 in 2014/15 from a baseline of 718.6 in 2012/13.</td>
</tr>
<tr>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>Reduce the proportion of patients reporting a poor experience of hospital care by 4.9% by 2018/19</td>
</tr>
<tr>
<td>Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community</td>
<td>Reduce the proportion of people reporting poor experience of General Practice and Out of Hours Services by 2.5% by 2018/19</td>
</tr>
<tr>
<td>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
<td>Have prevented 2,010 hospital emergency admissions over 5 years NB It is accepted that this is a proxy measure</td>
</tr>
</tbody>
</table>

Calculated using the baseline numbers supplied in NHS England Levels of Ambition Atlas measure (OF1a), for the movement in the PYLL
<table>
<thead>
<tr>
<th>NATIONAL OUTCOMES MEASURES FOR HEALTH AND WELLBEING</th>
<th>THE IMPACT WE WILL MAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-elective admissions in to hospital (general &amp; acute), all-age, per 100,000 population</td>
<td>Baseline years 14 /15 figures from CCG plan 9748</td>
</tr>
<tr>
<td></td>
<td>Planned for performance period Jan - Dec 15 = 9602</td>
</tr>
<tr>
<td></td>
<td>(First Finished Consultant Episode)</td>
</tr>
<tr>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>Baseline,2013/2014 88.6</td>
</tr>
<tr>
<td></td>
<td>Planned 2014/2015 92.5</td>
</tr>
<tr>
<td></td>
<td>Planned 2015/2016 87</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>Baseline 2013/2014 88.6</td>
</tr>
<tr>
<td></td>
<td>Planned 2014/2015 92.5</td>
</tr>
<tr>
<td></td>
<td>Planned 2015/2016 92.6</td>
</tr>
<tr>
<td>Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).</td>
<td>Baseline 2013/2014 2361.6</td>
</tr>
<tr>
<td></td>
<td>Planned 2014/2015 2281.2</td>
</tr>
<tr>
<td></td>
<td>Planned 2015/2016 2144.3</td>
</tr>
<tr>
<td>Reported on NGPPS 6 monthly. In the last 6 months had enough support from local services or organisations to help manage long term health conditions. Using weighted results scoring as per NHS Outcomes Framework indicator 2.1.</td>
<td>Baseline 2013/2014 70.5</td>
</tr>
<tr>
<td></td>
<td>Planned 2014/2015 74.3</td>
</tr>
<tr>
<td></td>
<td>Planned 76.5</td>
</tr>
<tr>
<td>The metric is the count of readmissions expressed as a percentage of relevant Non-Elective admissions. The national metric for this has not been used as it is only reported annually. The methodology for the metric has been applied to local data to be able to provide a regularly reported metric. However it is not possible to age standardise this data locally. Readmissions and Non-Elective emergency spell activity at main acute providers as determined using the algorithm agreed within the national acute provider contract based on ONS resident population. Definition as per Monitor guidance 2014/15 National Tariff Payment System - revised 26/2/2014, clause 6.3.2 Emergency readmissions within 30 days. (<a href="http://www.monitor.gov.uk/NT">http://www.monitor.gov.uk/NT</a>).</td>
<td>Baseline 2013/2014 14.3</td>
</tr>
<tr>
<td></td>
<td>Planned 2014/2015 14.3</td>
</tr>
<tr>
<td></td>
<td>Planned 2015/2016 14.3</td>
</tr>
</tbody>
</table>

Further details provided in template (version 3) BCF East Riding of Yorkshire -part 2 30.11.14
c) What changes will have been delivered in the pattern and configuration of services over the next five years and how will BCF funded works contribute to this?

<table>
<thead>
<tr>
<th>Our major objectives need to be managed effectively to ensure that we deliver our plan, they are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• an increasingly ageing population;</td>
</tr>
<tr>
<td>• rising demand due to the increase in complex patients predominantly linked to ageing;</td>
</tr>
<tr>
<td>• advancing technology in healthcare and in general everyday life;</td>
</tr>
<tr>
<td>• lifestyle choices around food consumption, exercise and healthy choices;</td>
</tr>
<tr>
<td>• financial uncertainty with regard to funding allocations and rising demand and a need to deliver savings to provide investment funding as required to deliver the plan;</td>
</tr>
<tr>
<td>• rurality in terms of access to and delivery of services;</td>
</tr>
<tr>
<td>• provision of high quality services and meeting national and local performance and outcome targets.</td>
</tr>
</tbody>
</table>

To mitigate and manage our challenges to ensure delivery of our plan we need to seize the following main opportunities:

| • service integration with partner organisations across social care, health and the wider community to reduce fragmentation; |
| • the use of non-traditional contracting methods which could provide innovative models of delivery; |
| • technology advances and use of mobile devices; |
| • choice of treatments, service providers and lifestyle choices; |
| • partnership working with traditional and non-traditional service providers, including the voluntary sector and community groups; |
| • how we use the health and social care estate to its optimum and to provide opportunities to work together. |

The opportunities provide the basis for our reformed service configuration:

| • Self-care, care ownership and prevention of health / social care needs deterioration - increasing numbers of residents in the East Riding will be confident to manage their own health and social care needs through their own actions to monitor and maintain their level of health and independence with rapid access to appropriate professionals when additional help/support is required. |
| • Consistency of service offer - because of the geographical spread and level of rurality of the East Riding of Yorkshire the consistency of service availability and responsiveness can be challenging. Over the next five years we are committed to improving the minimum level of consistency of service delivery across all parts of the East Riding whilst reflecting the often diverse needs of the local populations |
| • Health and Care focused around an individual’s needs and co-production and ownership of care and health service packages - individuals and their carers, where appropriate, will be central to the development of agreed integrated health and care plans which deliver the core identified health and care needs. |
| • Improved access to an agreed range of services; including some being provided 24/7 |

(i) Accessibility to services needs to change:

(a) our residents are becoming much more technologically aware and dependant. We will as a health and care community have embraced this and will be utilising a wide range of technological systems and processes to promote
easier access to information, advice and support whilst recognising the most vulnerable of our population may not have full access to technological solutions.

(b) whilst there remains a role in having dedicated points for delivery such as hospitals, clinics and health centres, we will have reviewed our estates and be using them more effectively across a range of services. For example Haltemprice Leisure Centre now has a GP Practice within its building footprint, making better use of the existing estate whilst improving the quality of the environment for the differing services.

(ii) Not all services can, or need to be, delivered 24/7. Where it is jointly agreed that service access is required 24/7 this will be put in place following an agreed programme of service redesign. This will include services being delivered across all health and care sectors and will be modelled upon existing, successful, 24/7 services.

Integrated Services

Service and professional boundaries and barriers will have been reduced enabling truly integrated services to be delivered with each member of the health and care team contributing their unique knowledge / skills but sharing a core level of competency to minimise duplication of assessment, interventions and visits.

Community Hubs

In order to support the delivery of individualised care either in a patient’s own home or within the local community we are developing a network of community hubs which will bring together different aspects of care into a single, flexible grouping which may, or may not depending upon the locality, have a central physical hub or may be a virtual hub linking the services across a more geographically disperse area. The diagram below illustrates the increasing prominence of community based services.
The following diagram provides an illustration of the differing aspects that we have unified to ensure that our proposed community based tier of services meet the needs of the local population. It covers our offer to our population, the different service tiers, risk stratification and a brief overview of how we expect services to be split between primary/community and acute care.

### Housing Support and Assistive Technology

The East Riding of Yorkshire Housing Strategies for Older and Vulnerable People recognise that in order to meet people’s needs the Council and its partners must plan strategically to deliver housing services that are suitable, both now and in the future. The strategies align closely with the Health and Wellbeing Strategy.

It is recognised that supported and specialist housing has a critical role in supporting people who are vulnerable or disadvantaged as a result of their age, ill-health, disability or circumstance to live independently. At a time of economic downturn, there is an increasing emphasis on reducing reliance on high cost care and on reducing hospital admissions. There is a need to spend a greater percentage of scarce public resources on effective preventative lower level services which can divert people from needing more expensive interventions such as residential care or hospital treatment, by supporting them to remain safely in the community.

Appropriate housing, housing related support and assistive technology are crucial elements of such preventative services.
Role of the Better Care Fund

The role of the Better Care Fund (BCF) programme is to act as an enabler to accelerate the introduction of the vision and plans articulated within the Joint Health and Wellbeing Strategy and Clinical Commissioning Groups 5 year strategic plans. Due to the fact that the underlying principles of the BCF are inherent in local plans there are no service changes that would not occur if the BCF was not present, however the timescales would be longer and, therefore, the positive impact that we expect from the changes would be delayed.

We have a clear vision running through our BCF Plan, Joint Health and Wellbeing Strategy and Clinical Commissioning Group Strategic Plans which will deliver a systematic change in the way people access services, both in and out of hospital. Through a reduction in acute hospital based activity and an increased use of home based and community intervention these changes will not only deliver more integrated care, but also improve the experiences and outcomes for the East Riding population.

The BCF is providing a focused environment working at pace in which to progress our existing plans of work.

The BCF work is enabling the Health and Wellbeing Board - and its integral organisations to look at organisational and service integration outside of the usual service demands, enabling them to come together to develop a strategic service change plan arising from integration and redesign opportunities.

The Better Care Fund Programme Board is the delivery vehicle for the BCF programme and responsible for delivery of the agreed projects. To help ensure that the Programme Board can deliver its objectives one-off funding has been approved to aid in the full implementation of the BCF. Decisions on specific spend from this one-off funding can be made at the BCF Programme Board where the relevant budget holders are represented. Ongoing base budget funding will be managed via the s75 pooled budget agreement.

The Better Care Fund programme is a major transformational change programme for the health and social care sector and governance arrangements are outlined in more detail in section 4 of this Plan.

The role of the Better Care Fund is to ensure that the system transformation required for health and social services is happening locally and in partnership. Section 6 of this paper demonstrates that East Riding has a five-year plan that will deliver the aims of the Better Care Fund.
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The above diagram highlights the different support services within the County and widespread geographical area which has to be considered when planning health and social care services.

In establishing the opportunities and challenges for service redesign and integration that has been translated into our JHWS and CCG Strategic Plans the data available to us was analysed to help us understand where the opportunities for positive impact were.

The non-elective spells trend data provided by NHS England shows that ERYCCG has managed an overall average annual reduction in non-elective activity of 0.6% since 2010/11 to 2013/14 compared to a national growth of 1.0% over the same period.

There has been an improving trend of reductions; most of the reduction has been seen in the last 2 years, with 1% in 2012/13 and 2% in 2013/14. Local data for the first three months of 2014/15 show that ERYCCG has made a further reduction of 3.5% against the
same period last year. This is despite an underlying growth in the over 65-years population of over 3% p.a.

Current position and historic movement

The PCT and now CCG has been delivering successful QIPP schemes for many years which show in the non-elective spells trend data provided by NHS England. ERYCCG has managed an overall average annual reduction in non-elective activity of 0.6% since 2010/11 to 2013/14 compared to a national growth of 1.0% over the same period. Most of the reduction has been seen in the last 2 years, with 1% in 2012/13 and 2% in 2013/14. Local data for the first three months of 2014/15 show that the CCG has made a further reduction of 3.5% against the same period last year, since implementing the latest QIPP programme. This is despite an underlying growth in the over 65 population of over 3% p.a. and is exceptional when compared with our Peers (6.5%) and National (4.5%) change over the same period.

Chart showing latest trend

The above chart demonstrates the positive improvement that the CCG has made on Non-elective admissions especially when compared against the rise in admissions that have been seen at our peers.
(Non-elective (G&A) historic figures - mapped from UNIFY data)

<table>
<thead>
<tr>
<th></th>
<th>Annual changes</th>
<th>Average change from 2010-11 to 2013-14</th>
<th>Q1 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>HWB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historic Non-Elective FFCEs</td>
<td>34,564</td>
<td>33,964</td>
<td>33,758</td>
</tr>
<tr>
<td>East Riding of Yorkshire (PCT/CCG)</td>
<td>2.0%</td>
<td>-1.7%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Peer group</td>
<td>4.6%</td>
<td>-1.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>England median</td>
<td>3.7%</td>
<td>0.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>England Top 25th Percentile</td>
<td>0.3%</td>
<td>-3.2%</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

The CCG has continued the very strong performance on management of its emergency admissions started by the legacy PCT. The NHS Comparator site for the last year that data is available 2012/13 shows that the PCT had a rate per 1000 standardised population of 78.3 that was better than the Peer group average and significantly better than the national average. This equates to 3,461 less admissions than the national average:

Baseline Emergency admissions | Standardised rate | Equivalent Spells |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
<td>Total Spells</td>
</tr>
<tr>
<td>East Riding of Yorkshire</td>
<td>78.3</td>
<td>27381</td>
</tr>
<tr>
<td>Peer group</td>
<td>80.8</td>
<td>28841</td>
</tr>
<tr>
<td>England median</td>
<td>88.2</td>
<td>30842</td>
</tr>
</tbody>
</table>

This good starting position and overall reduction has been as a result of several years of a successful QIPP programme. Schemes also delivered improvements in other areas and resulted in overall savings of around £3m p.a. The schemes which have delivered Emergency admissions reductions are:
Falls risk assessments have been part of local health and social care services for many years and Level 1 and 2 services have been in place over this time. A Level 3 service has been in place since December 2013. We saw a 27% reduction in fractured neck of femur in 2013/14 and have seen a reduction in emergency admissions for falls of 4.8% for the first quarter of 2014/15.

Current plans reflect the CCGs good performance on non-elective admissions compared to peers and reductions made to date. Plans are based on sustainability though building in to the Plan reductions in admissions that match the underlying rate of growth of around 3%, on ACS admissions or 1.2% on all emergency admissions.

**Analysis of the population**

The CCG has a higher than national average elderly population and growth in this sector and a decline in the younger working age population.
The risk stratified profile showing the potential for patients with Long Term Conditions with co-morbidities is:

<table>
<thead>
<tr>
<th>RISC Level</th>
<th>Population Percentile</th>
<th>Number of Patients</th>
<th>LTC greater than or equal to 1</th>
<th>LTC greater than or equal to 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0% to 1/2 % (Level 3)</td>
<td>1,614</td>
<td>1,403</td>
<td>537</td>
</tr>
<tr>
<td>2</td>
<td>&gt; ½% to 5% (Level 2)</td>
<td>14,497</td>
<td>8,307</td>
<td>1,675</td>
</tr>
<tr>
<td>1</td>
<td>&gt; 5% to 25% (Level 1)</td>
<td>60,295</td>
<td>9,964</td>
<td>1,448</td>
</tr>
<tr>
<td>0</td>
<td>&gt; 25% to 100% (Level 0)</td>
<td>223,817</td>
<td>5,888</td>
<td>302</td>
</tr>
<tr>
<td>Total Population</td>
<td></td>
<td>300,223</td>
<td>25,562</td>
<td>3,962</td>
</tr>
</tbody>
</table>
A consistent theme of the projects is in managing the patient’s condition to prevent crises resulting in emergency admissions. The latest of which involves GPs managing patients with two long term conditions or more, and the usage of the risk stratification tool is a required component of this service. Risk stratification has been used by many Practices for several years to support identification and management of patients care through multi-disciplinary teams.

This is based on 2013/14 data.
**Assessment of potential**

<table>
<thead>
<tr>
<th>Assessment of areas of potential</th>
<th>Qtr1</th>
<th>Qtr1</th>
<th>Qtr1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010/11</td>
<td>2011/12</td>
<td>2012/13</td>
</tr>
<tr>
<td><strong>Previous actions:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD))</td>
<td>760</td>
<td>799</td>
<td>807</td>
</tr>
<tr>
<td>Falls &gt;65's (excl Pock)</td>
<td>-</td>
<td>1,535</td>
<td>1,274</td>
</tr>
<tr>
<td>CHD (CHF)</td>
<td>1,105</td>
<td>1,175</td>
<td>1,169</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,865</td>
<td>3,509</td>
<td>3,250</td>
</tr>
<tr>
<td><strong>Other potential areas identified in guidance:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection/pyelonephritis</td>
<td>536</td>
<td>643</td>
<td>803</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>265</td>
<td>238</td>
<td>297</td>
</tr>
<tr>
<td>Convulsions and epilepsy</td>
<td>520</td>
<td>479</td>
<td>396</td>
</tr>
<tr>
<td>ear, nose and throat infections</td>
<td>36</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>Asthma &lt; 19's(Per Neil)</td>
<td>108</td>
<td>102</td>
<td>134</td>
</tr>
<tr>
<td>CHD - Cardiac rehab</td>
<td>1,105</td>
<td>1,175</td>
<td>1,169</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,570</td>
<td>2,674</td>
<td>2,623</td>
</tr>
</tbody>
</table>

As demonstrated above the overall starting position is good, however subsequent ongoing improvements do mean that the remaining potential reductions will be harder to identify and achieve.

The NHS Comparator site shows that the PCT was in the mid-range (78.3) for their peer group and below the Peer (80.8) and national average (88.2) per 1000 population. Although this is not at CCG or Health and Wellbeing Board level and is 2012/13 data it is indicative of the current performance. Therefore the CCG is already well on the way to delivering this potential and, given recent information, may now have already achieved this.

North Somerset PCT has the lowest rate at 66.1; if the CCG aimed for this rate it would need a reduction of 6,400 spells. This would require removal of all avoidable admissions. Although not a realistic target it does highlight the potential to still improve. Further review of the differences between ERY and Nth Somerset would be needed to identify potential and possible projects.

**Identified projects**

The CCG has therefore developed a set of projects that focus on Ambulatory Care Sensitive conditions as recommended by the Kings Fund and has set a target reduction of 1,130 for these projects.

The Risk Stratification identifies CHD as an area which has most potential for the CCG and to this end we have also developed a project to implement Cardiac Rehabilitation across all Localities.
COPD is a disease where we have already seen success in one locality with Pulmonary Rehabilitation and the segmentation data shows that there is further potential therefore we are expanding the service across the rest of the CCG.

A full list of the projects to be implemented and the target reductions is shown below:

<table>
<thead>
<tr>
<th>New Projects 2015/16</th>
<th>Planned reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spells</td>
</tr>
<tr>
<td>CHD - Cardiac Rehabilitation</td>
<td>- 268 -0.8%</td>
</tr>
<tr>
<td>Ambulatory care - Community hub GH&amp;WW</td>
<td>- 106</td>
</tr>
<tr>
<td>Ambulatory care - Community hub Other Localities</td>
<td>- 294 - 1,130 -3.4%</td>
</tr>
<tr>
<td>Ambulatory care - HEYH Frailty model</td>
<td>- 730</td>
</tr>
<tr>
<td>COPD - Pulmonary Rehab</td>
<td>- 71 -0.2%</td>
</tr>
<tr>
<td>MH Nurse in ED @ HEYH</td>
<td>- 86 -0.3%</td>
</tr>
<tr>
<td>Falls prevention - level 3 service</td>
<td>- 124 -0.4%</td>
</tr>
<tr>
<td>Pocklington Health &amp; Social Care Hub</td>
<td>- 73 -0.2%</td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>- 22 -0.1%</td>
</tr>
<tr>
<td>Total new projects for BCF</td>
<td>- 1,774 -5.5%</td>
</tr>
</tbody>
</table>

These projects give an overall reduction against the current H&WBB Emergency Admissions of 5.5%; however this will be delivered over several years.

The risk stratification also identifies that there may be some potential within the management of patients with Diabetes. Some of these will be picked up through the LTC Comorbidity clinics; however, it may be worthwhile developing a specific project for diabetes. Once the existing and planned scheme have been implemented and evaluated, we will then look into the potential for a diabetes project.

**Underlying growth**
As shown earlier, the CCG has a large and growing elderly population which drives increases in demand for elective and emergency care. This growth is around 3%. Therefore, we have calculated what the likely impact of the underlying growth is on our plans as follows:

<table>
<thead>
<tr>
<th>Calculation of growth on emergency spells.</th>
<th>Pop Growth</th>
<th>% of Pop</th>
<th>NEL Proportion</th>
<th>Average NEL growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying growth &gt;65</td>
<td>3.30%</td>
<td>23.30%</td>
<td>51%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Underlying growth &lt;65</td>
<td>-1.30%</td>
<td>76.70%</td>
<td>49%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Emergency spell multiplier</td>
<td></td>
<td></td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>Adjusted activity growth</td>
<td></td>
<td></td>
<td></td>
<td>2.8%</td>
</tr>
</tbody>
</table>
Elderly Population growth impact on emergency spells

<table>
<thead>
<tr>
<th>Underlying growth multiplier</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Change</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>National PCT based NEL activity</td>
<td>5,379,586</td>
<td>5,466,776</td>
<td>87,191</td>
<td>1.6%</td>
</tr>
<tr>
<td>(Use 2011/12 as shift to CCG creates variation between years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National resident populations</td>
<td>53,107,169</td>
<td>53,493,729</td>
<td>386,560</td>
<td>0.7%</td>
</tr>
<tr>
<td>Ratio of increased activity to growth in pop</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With the phasing of the implementation of the planned projects and the underlying growth impact, means that there will only be a 1.0% reduction in emergency admissions in the Calendar year 2015/16.

Integration

Although there have been instances of limited integration of services within the area e.g. Integrated Hospital Team, have mainly been in the form of separate teams working together within the same environment, with overlapping approaches. The local area is moving towards integration and the mechanisms and structures have been established to support this.

There has been a longstanding ambition to shift more health care from hospitals to settings closer to people’s homes, and from reactive care to prevention and proactive models based on early intervention. There has been some progress, with significant reductions in lengths of stay and admissions.

There is an emerging consensus about the impact that community services can have and what is needed to improve their effectiveness. The main steps identified are:

- reducing the complexity of services;
- wrapping services around primary care;
- building multidisciplinary teams for people with complex needs, including social care, mental health and other services;
- supporting these teams with specialist medical input and redesigned approaches to Consultant services – particularly for older people and those with chronic conditions;
- creating services that offer an alternative to a hospital stay;
- building an infrastructure to support the model based on these components, including much better ways to measure and pay for services;
- developing the capability to harness the power of the wider community.

This approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complimented by highly flexible, responsive community and social care services. In social care, steps have already been undertaken towards this goal through the development of a range of 24/7 reablement social care services, which are partially funded through the transfer of monies from the ERYCCG.
The Kings Fund identified that up to 18% of admissions for Ambulatory Care Sensitive (ACS) conditions could be prevented if performance matched the top quintile of Local Authorities. 18% of our 6,800 ACS admissions equate to around 3.7% of our total emergency admissions. The risk stratification software used in East Riding has identified a cohort of patients who, with increased access to community based services, have the potential to prevent 7,023 admissions p.a. (this is level 1 and 2 as we believe level 3 patients are likely to still require acute admission).

As previously demonstrated above, using the NHS Comparator site and local data, the PCT/CCG has already achieved considerable reductions in emergency admissions.

This is as a result of the implementation of a comprehensive range of urgent care focussed QIPP schemes. These projects have been monitored each year as part of the QIPP programme and have proven their effectiveness overall. The QIPP projects were based around close working between health teams across Acute, Community and Primary care and social services.

A consistent theme of the projects is in managing the patient’s condition to prevent crises resulting in emergency admissions. An example of this involves GPs pro-actively managing patients with two long term conditions or more, and the usage of the risk stratification tool is a required component of this service. Risk stratification has been used by many Practices for several years to support identification and management of patients care through multi-disciplinary teams. The risk stratified profile for the populations is:

<table>
<thead>
<tr>
<th>RISC Level</th>
<th>Population Percentile</th>
<th>Number of Patients</th>
<th>Unplanned Chronic Admits</th>
<th>A&amp;E Attends</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0% to ½% (Level 3)</td>
<td>1,614</td>
<td>2,926</td>
<td>4,067</td>
</tr>
<tr>
<td>2</td>
<td>&gt; ½% to 5% (Level 2)</td>
<td>14,497</td>
<td>5,749</td>
<td>12,768</td>
</tr>
<tr>
<td>1</td>
<td>&gt; 5% to 25% (Level 1)</td>
<td>60,295</td>
<td>1,274</td>
<td>13,808</td>
</tr>
<tr>
<td>0</td>
<td>&gt; 25% to 100% (Level 0)</td>
<td>223,817</td>
<td>225</td>
<td>32,286</td>
</tr>
<tr>
<td>Total Population</td>
<td></td>
<td>300,223</td>
<td>10,174</td>
<td>62,929</td>
</tr>
</tbody>
</table>

NB This is based on 2013/14 data.

Falls risk assessments has also been part of local health and social care services for many years and Level 1 and 2 services have been in place over this time. A Level 3 service has been in place since December 2013. We saw a 27% reduction in fractured neck of femur in 2013/14 and have seen a reduction in emergency admissions for falls of 4.8% for the first quarter of 2014/15.

Current plans reflect ERYCCG’s good performance on non-elective admissions compared to peers and the reductions made to date. Plans are based on sustainability though building in to the Plan reductions in admissions that match the underlying rate of growth of around 3% on ACS admissions or 1.2% on all emergency admissions.

These steps correspond with the vision that we have in the East Riding to improve the services to our local residents and service users that were set out in Section 2. The BCF
then provides the opportunity for us to develop the models that are required to deliver on these aims.

There are a number of examples of how we are already improving integration within the local area including the development of Ambulatory Care Models across both community and hospital settings (see annex 1). In this instance we are defining ambulatory care as care that is given in either the individual’s own home or a community setting (community ambulatory care) examples of which are (a) The Goole, Howdenshire & West Wolds Rapid Response Service pilot b) The Pocklington Health & Social Care Hub (see below) or care that is provided within a hospital setting in a dedicated ambulatory care or frailty facility where individuals are not admitted to the hospital but are assessed, treated and care plans developed in the assessment service where clinically appropriate (hospital based ambulatory care) also see annex 1.

These developments involve bringing together Primary, Community, Hospital and Social Care services into a single service function to work together to:

- reduce duplication;
- increase the impact of the care planning and implementation;
- support maintenance of an individual at home without the need to attend a hospital facility if clinically appropriate;
- facilitate access to dedicated assessment, treatment and care planning hospital based facilities designed to ensure that individuals stay within the hospital for a matter of hours and are not admitted to the hospital unless this is seen as clinically appropriate.

We are also working to improve how health and social care work within the wider community to deliver integrated services to individuals in a community setting through our Neighbourhood Care Services Transformation (section c below).

a) The Goole, Howdenshire and West Wolds Rapid Response Service Locality Hub is a 12 month pilot organised around 7 GP practices to reduce the number of unplanned hospital admissions targeting the top 2% of most vulnerable patients. The scheme involves the creation of a rapid response ‘team’ in the community who will provide urgent access to the appropriate health and/or social care services, i.e. within 2 hours, at times of health and social care deterioration and within the same timeframe for those individuals in hospital and identified as suitable for ‘discharge to assess’. Access to the service will be via a Health Care Coordinator who will broker the appropriate health and/or social care response as well as monitoring and tracking the patient’s progress.

b) The Pocklington Health and Social Care Hub is to ensure that frail, elderly and vulnerable people are supported and enabled to be as healthy, active and independent as possible in their own home for as long as possible and, where necessary, to support these individuals in a crisis and to ensure that there is a timely and efficient multi-agency response when a crisis occurs.

The key principles of the hub are:

- Person at the heart of the Hub;
- An MDT approach which will underpin the care support that is provided;
- Organisational communication and recognising each other’s pressures;
• Prioritisation of resources within statutory frameworks.

The Hub provides better, more coordinated care, closer to home and delivers:

• accessible and flexible services, via a single point of entry;
• seamless and holistic health and social care in the right place at the right time;
• the promotion of self-care of long term conditions; maximising people’s independence;
• support to live healthy and ‘full’ lives by reducing the need for intensive and costly interventions;
• support to people to retain or improve levels of independence via short term reablement.

c) The Neighbourhood Care Services Transformation Programme was initiated in December 2013 to draw together a series of discrete projects which collectively will transform the delivery of Neighbourhood Care Services across the East Riding, creating a single point of access to Health and Social Care.

The service model focuses on care homes, reablement, housebound patients, management of Long Term Conditions and an effective tissue viability service. It is underpinned by the effective use of technology and a fit for purpose workforce which together demonstrates effective outcomes for people who receive this service.

Since the programme’s implementation a number of developments have either been applied or are in the initiation phase which include:

• Monthly joint physical and mental health MDT meetings to ‘holistically’ case manage patients who are receiving both physical and mental health clinical intervention commenced in May 2014.
• Initiation of a streamlined 24 hour flexible nursing service for patients of the East Riding, to ensure the ability to deliver the capacity at times of high demand. This is being achieved by moving to a 24 hour service delivery model, which is more responsive and better equipped to meet the ever increasing demands of the patient population. Where there is more than one different working practice their functions, systems and processes are being assimilated to implement a seamless pathway of care.
• Skills sharing for physical and mental health staff includes; Falls and Pressure Ulcer Risk Assessments. Future development of processes will include the Mental Health Trigger Assessment Tool and National Early Warning Score (NEWS).
• Optimisation of clinical systems to provide a more efficient IT solution enabling better access to the latest information and supporting seamless communications between clinicians.
• Development of a Single Point of Contact to move towards one telephone number for patients to access clinical intervention across East Riding for Neighbourhood Care Services, Stroke Team, Respiratory Team and the Cardiac Team. In parallel to this we are currently working towards a Single Point of Contact for Health & Social Care.

Overall benefits anticipated from delivery of the programme include:

• Patients will receive a holistic approach to their care by the delivery of integrated
mental and physical health services which include improved documented assessment and care plans.

- Clear transparent pathways of care to include a single point of access, avoidance of hospital admissions and timely discharge.
- Health and wellbeing, independence and promotion of self-care, ensuring care is effectively coordinated regardless of provider.
- Competent, capable and confident workforce.
- Improved Information Technology demonstrating better access to latest information to improve the quality of care for the patient and seamless communications between shared services.

This approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complimented by highly flexible and responsive community and social care services. In social care, strides have already been undertaken towards this goal through the development of a range of seven-day, 24/7 reablement social care services, which are partially funded through the transfer of monies from the ERYCCG.

It is recognised by the stakeholder organisations that the current health and social care system in the East Riding needs to change to meet the on-going challenges of providing services to the local population. The BCF is seen as the enabler to drive these changes forward and this is reflected in the plan. As this section details, the East Riding is already seeing the benefits of innovative approaches to integrated service delivery and we aim to build on these successes going forward. The intention is to use the opportunities that the BCF provides to pilot ideas within the localities, to then assess and refine these approaches to create an integrated service delivery model that can be adopted widely within the East Riding.

The above examples and the additional examples contained within Annex 1 will enable us to remodel those aspects of health and social care that fall within the remit of the BCF Plan and provide improved patient/individual care through:

- Personalised care planning taking into account an individual’s, and their family/carers, views on what care they wish to experience – this will be supported by the use of self assessment questionnaires designed to help individuals to identify those factors that they are concerned about or that are important to them
- Reduction in duplication of assessments, information gathering wherever possible giving individuals more control, over where and what data is held about them
- Promotion of self care and self management through early intervention and education when a disease is at an early stage reducing an individuals need for more intensive health and social care interventions or, where these are required, ensuring that the care is tailored to need and short term with a view to reablement and not long term care needs
- Giving individuals time to recover and regain their optimum levels of confidence/independence before a decision is made regarding longer term care needs

Without integrated services we will not be able to deliver the above. Each professional has expert knowledge and skills in their chosen profession but it is recognised that an individual cannot be treated as different diseases or care needs. Each disease or care...
need an individual has will impact upon the other and without working as an integrated service there will be no recognition of these impacts and an individual’s chance of recovering to an optimal level will be reduced when compared to the benefits of being treated as a whole person not as a disease.

It is recognised by the stakeholder organisations that the current health and social care system in the East Riding needs to change to meet the on-going challenges of providing services to the local population. The BCF is seen as the enabler to drive these changes forward and this is reflected in the plan. As this section details, the East Riding is already seeing the benefits of innovative approaches to integrated service delivery and we aim to build on these successes going forward. The intention is to use the opportunities that the BCF provides to pilot ideas within the localities, to then assess and refine these approaches to create an integrated service delivery model that can be adopted widely within the East Riding.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

BCF Plan developments are aligned and interdependent with ERYCCG and ERYC strategic planning and commissioning priorities, both of which are linked to the JSNA, as well as plans that providers have for service provision. The vision for the delivery of integrated care is embedded also within strategies for Joint Adult commissioning, Older People, carers and Community Services and is also at the core of the CCG’s two year operational Plan.

A high-level overview of the BCF timeline for the East Riding is presented on pages 37 and 38. The full project plan is attached as appendix 3.
## Overview Project Plan

<table>
<thead>
<tr>
<th>Area</th>
<th>Task</th>
<th>Strategic Lead</th>
<th>Operational Lead</th>
<th>RAG</th>
<th>Start Date</th>
<th>End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme Management</strong></td>
<td>Governance &amp; Reporting</td>
<td>Alex Seale</td>
<td>PMO</td>
<td>G</td>
<td>May 14</td>
<td>Mar 15</td>
<td>Programme Board and Resource &amp; Infrastructure groups established and Terms of Reference finalised. Central PMO functioning effectively with agreed processes and systems. Governance and reporting structure in place and Decision Record Process in place to approve and track funding requests.</td>
</tr>
<tr>
<td></td>
<td>Communications &amp; Engagement</td>
<td>Lauraine</td>
<td>Quintina</td>
<td>G</td>
<td>Aug 14</td>
<td>Ongoing</td>
<td>Communications &amp; Engagement Plan in place; well established communication methods. 'Key messages' from each Programme Board to Carers Advisory Group. Publicity and reporting protocols established and schedules agreed. Some engagement events delivered, as per schedule, and events planned.</td>
</tr>
<tr>
<td></td>
<td>Single Point of Contact (SPoC)</td>
<td>Lauraine</td>
<td>John</td>
<td>G</td>
<td>Feb 14</td>
<td>Nov 15</td>
<td>Phase 1 implemented at Hessle Grange with first tranche of services routed in. Options Appraisal for Phase 2 presented and option agreed by Board – Implementation Plan to be developed in the new year. Phase 3 will see a fully operational SPoC will all services routed through a single point. Operations will be rationalised and optimised through Phase 4.</td>
</tr>
<tr>
<td><strong>Resource &amp; Infrastructure</strong></td>
<td>Co-location Community Hubs</td>
<td>Will Uglow</td>
<td>James Timm</td>
<td>G</td>
<td>Oct 14</td>
<td>Jun 15</td>
<td>Register of health and social care facilities completed. Phase 1 locations agreed. Transport working group established; an integrated transport solution to be agreed ERYC and YAS PTS, utilising YAS SPA and Transport Decision Tree Framework and ERYC transport solutions. Settlement Review – estate data collection templates have been issued.</td>
</tr>
<tr>
<td></td>
<td>Single Shared Electronic Health &amp; Social Care Record</td>
<td>Lee Rickles</td>
<td>Lee Rickles</td>
<td>G</td>
<td>Mar 14</td>
<td>Nov 18</td>
<td>Baseline of organisation informatics capabilities complete and gap analysis undertaken. Data exchange and IT standards to be applied to the solution defined. Information governance controls established. Business Case for the solution in development; to be presented Jan 2015.</td>
</tr>
<tr>
<td></td>
<td>Risk Management</td>
<td>Alex Seale</td>
<td>Lauraine Walker</td>
<td>A</td>
<td>Aug 14</td>
<td>Mar 15</td>
<td>Single programme management arrangement established with BCF partners. Risks managed through the Resource and Infrastructure group and reported to BCF Board. Section 75 to be agreed.</td>
</tr>
<tr>
<td></td>
<td>Hospital Mental Health Liaison Service</td>
<td>Peter Choules</td>
<td>Jo Kent</td>
<td>G</td>
<td>Nov 14</td>
<td>Jan 15</td>
<td>Hull and East Yorkshire NHS Hospital Trust Emergency Department - will prevent 36 admissions. Performance monitoring via NEL admissions. Need to recruit staff and identity space at Hull Royal Hospital.</td>
</tr>
<tr>
<td></td>
<td>Children’s Asthma</td>
<td>Karen Ellis</td>
<td>Alison Cockerill</td>
<td>G</td>
<td>Oct 14</td>
<td>Sep 15</td>
<td>East Riding Asthma project group established. Action Plan will be developed by Jan 2015, to include awareness raising and training, for implementation Sep 2015. Pilot to be iterative process, taking lessons learned at each phase.</td>
</tr>
<tr>
<td></td>
<td>Cardiac Rehabilitation</td>
<td>Matthew Groom</td>
<td>Debbie Pattison</td>
<td>G</td>
<td>Nov 14</td>
<td>Mar 18</td>
<td>Reduction in emergency admissions: 89 in 2015/16; 173 in 2016/17; 268 in 2017/18 by promoting lifestyle change, dietary habits and increased levels of self-care and condition awareness. Existing Cardiac Rehab. Service will be expanded.</td>
</tr>
<tr>
<td></td>
<td>End of Life Care</td>
<td>Karen Ellis</td>
<td>Debbie Pattinson</td>
<td>A</td>
<td>Feb 14</td>
<td>Mar 16</td>
<td>Phase 1 - existing palliative and end of life services mapped; activity collated to identify gaps. Best practice models scoped to inform the development of the model. Further analysis of unmet need required – options appraisal for ERYCCG due 06 Jan 2015 for Phase 2 implementation.</td>
</tr>
<tr>
<td></td>
<td>Enhanced Hospital Team (Scarborough/York)</td>
<td>Vicky Lawrence</td>
<td>Scott Rayner</td>
<td>G</td>
<td>Nov 14</td>
<td>Mar 15</td>
<td>Targets and impact measures agreed, to save 345 excess bed days through improved access to 7 day a week access to assessments to improve patient flow through acute hospital beds. 1.5 dedicated social worker posts to be based in Scarborough Hospital as part of the discharge team.</td>
</tr>
<tr>
<td></td>
<td>Enhanced Hospital Team HEYHT Castle Hill</td>
<td>Vicky Lawrence</td>
<td>Scott Rayner</td>
<td>G</td>
<td>Nov 14</td>
<td>Mar 15</td>
<td>Targets and impact measures agreed to support 7 day a week service to assessment and discharge planning.</td>
</tr>
<tr>
<td></td>
<td>OT Support for Reablement</td>
<td>Lianne Therkelson</td>
<td>Sally Smith</td>
<td>G</td>
<td>Nov 14</td>
<td>Mar 15</td>
<td>Bid signed off via Decision Record process; initial 12-week contract for posts to enable speedier approach to the commencement of Phase 1 of the project. On track to recruit staff and implement OT posts.</td>
</tr>
<tr>
<td>Discharges</td>
<td>Organisation</td>
<td>Code</td>
<td>Time</td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
<td>------</td>
<td>------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to Think Beds</td>
<td>ERYCCG</td>
<td>A</td>
<td>Apr 14</td>
<td>Mar 15</td>
<td>To save excess bed days, moving towards a Discharge to Assess model. Beds initially spot purchase in residential and nursing settings to enable timely mobilisation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical Home Support Service</td>
<td>Karen Ellis</td>
<td>G</td>
<td>Sep 15</td>
<td>Mar 15</td>
<td>Utilising existing community responder services to maximise use of staff skills and provide access through a single point (Driffield Hub), operating 24/7 supporting discharges for up to 72 hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Support &amp; Reablement</td>
<td>Karen Ellis</td>
<td>G</td>
<td>Sep 15</td>
<td>Mar 15</td>
<td>To save excess bed days – 566 over 12 months. Staff to be recruited and educated to raise awareness of service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pocklington Health &amp; Social Care Hub</td>
<td>Tim Maycock</td>
<td>G</td>
<td>July 14</td>
<td></td>
<td>Financial assessment conducted and targets and impact measures agreed. Resource gap analysis undertaken and staff to be recruited. Service model and pathways to be developed. Service go-live Dec 2014.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
September 2014 to March 2015

Finalise the Terms of Reference for the reconfigured Programme Plan and BCF Programme Board.
Complete detailed planning to implement the integrated models.
Launch the Locality Hub pilot, as part of the Ambulatory Care workstream.
Ensure new models are aligned with commissioning and strategic plans and contracting discussions for April 2015 onwards.
Introduce performance metrics reporting pathways.
Develop and agree upon the Section 75 agreement.
Capacity planning for revised workforce teams, where applicable.
Develop the BCF PMO function to full utilisation and functionality.
Expand the Better Care Fund Programme Board Concordat to link to the BCF resubmission.
Launch the Single Point of Contact to rationalise how community health contacts are dealt with and prepare for integration with social care call handing.

April 2015 onwards

Implementation of all BCF schemes.
Monitor impacts of BCF implementation against the agreed performance metrics.

It is recognised locally that following the submission, a review of the governance and programme arrangements will be required to ensure that they are fit for purpose. An extraordinary meeting of the BCF Programme Board on 23rd September 2014 will rebase the Programme Plan and redefine membership of the Board to fit the vision of the resubmission. Following this, and working closely with the workstream and project leads, a revised detailed programme plan, including milestones and interdependencies, will be created setting out the detailed steps for the implementation of the BCF plan.

b) Please articulate the overarching governance arrangements for integrated care locally

A BCF Programme Board has been established to provide leadership and to manage the delivery of the agreed programme of work. The Programme Board has responsibility for managing the key operational and strategic issues linked to the creation and implementation of the BCF plan. In order to support the delivery of the projects a Programme Management Office has been set up. The PMO also assists the BCF Programme Board to undertake their on-going role of overseeing the programme delivery, monitoring and assessing progress, managing programme interdependencies and assessing issues and risks as they arise. The Programme Board has representation from the key stakeholders including both CCGs, the Local Authority, acute and community providers as well as other stakeholders such as voluntary action services, Healthwatch and the carer’s advisory group. This multi-organisational approach provides the joint accountability required to push through the changes needed to deliver the BCF plan as well as the assurance that we have buy-in at all stages of development through to implementation.
Each work stream has also produced a Project Initiation Document and project Terms of Reference.

The original Concordat has been updated to reflect development of the Better Care Fund Partnership which has been approved by the BCF Programme Board and is being circulated to partners for signing, which is predicted to be completed by mid December. This revised version of the concordat is attached as Appendix 1. The concordat sets out the principles and commitments for integrated working and highlighting senior level commitment to the deliver the vision outlined within the BCF Plan. The development of the original Concordat helped to highlight the concerns that partner organisations had and, more importantly, the principles of integration and service user needs that everyone could agree to. This in turn helped to establish a commitment to joint working on the principles and beliefs that we had in common which proved useful in making progress, particularly across organisations where there was no shared history of working together. This will be refreshed and extended following the resubmission of this revised Plan.

The BCF Programme Board aims to mitigate risks and provide a systematic and consistent framework through which the local priorities are pursued and issues logged. This involves identifying risks, threats and opportunities for achieving these objectives and taking any necessary mitigating steps that are needed. An integrated approach will be taken so that lessons learned in one area of risk can be quickly shared throughout the system.

The creation of a pooled fund for joint use by NHS and Local Authority commissioners will be backed up by a Section 75 legal agreement. The monies to create this pooled fund are already being spent on existing services in the community, providing health benefits to the community (see section 6 for examples). The Section 75 documentation will be supported by a risk share agreement and, in line with the Concordat, all organisations have agreed to take steps to mitigate against destabilisation of health and care services.

Overall responsibility for the successful delivery of the BCF Plan and integrated services sits with the East Riding of Yorkshire Health and Wellbeing Board with both the BCF Programme Board and the Health and Social Care Executive providing assurance to them on progress against the Plan. The diagram at the end of this section provides details of the on-going governance structure and how issues can be escalated from the workstream level through to the Health and Wellbeing Board if advice and clarity are required.
c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track.

Within the governance structure above project leads are required to submit regular update monitoring reports which outline progress against key milestones identified in their Project Initiation Documents to both the Programme Management Office (PMO) and the BCF Programme Board. The PMO then identifies the dependences between projects and the impacts on critical paths to report them to the Board. Programme leads are required by the Board to implement remedial action to get back on track or present contingency plans where it is not possible to recover.

Governance structures for integration have a firm grounding in the existing health and social care arrangements across the East Riding and there are plans to strengthen this through the creation of a formal risk share and Section 75 legal document to define the pooled budget arrangements.

The Health and Wellbeing Board has a key role in integration and the BCF Programme board will submit regular progress reports providing a strategic oversight.
d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

<table>
<thead>
<tr>
<th>Annex Number</th>
<th>Scheme</th>
</tr>
</thead>
</table>
| 1             | Ambulatory Care incorporating:  
|               | ‣ Goole, Howdenshire and West Wolds Frailty Support Service  
|               | (Community Ambulatory Care Pilot)  
|               | ‣ Acute Ambulatory Care |
| 2             | Cardiac Rehabilitation |
| 3             | Collaborative Falls Pathway |
| 4             | Long Term Conditions Clinics |
| 5             | Pulmonary Rehabilitation |
| 6             | Reducing unnecessary Paediatric Asthma admissions and supporting better ambulatory care for children |
| 7             | Seven day working pilot at Castle Hill Hospital (HEY facing) |
| 8             | Enhanced Hospital Team (Scarborough Hospital, York Teaching Trust ) |
| 9             | Discharge Support and Reablement |
| 10            | Time to Think beds – HEY facing |
| 11            | Time to Think beds – Scarborough facing |
| 12            | Practical Home Support Service (PHS) |
| 13            | Short Term Assessment and Reablement Service (STARS) |
| 14            | Ambulatory Care –Pocklington Health and Social Care Hub |
| 15            | Hospital Mental Health Liaison Service in HEYHT Emergency Department |
5) RISKS AND CONTINGENCY

a) Risk Log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

<table>
<thead>
<tr>
<th>No</th>
<th>Summary of risk</th>
<th>Nature of Risk</th>
<th>Probability</th>
<th>Severity</th>
<th>Overall risk factor (likelihood *potential impact)</th>
<th>Mitigating Actions</th>
<th>Mitigating action undertaken by whom</th>
<th>Mitigating action undertaken by when</th>
</tr>
</thead>
</table>
| 1. | The acute hospital activity reductions (and associated financial cost reductions to commissioners) do not materialise as envisaged, primarily because emergency admission continue to rise due to demography and acuity of patient need. | Financial to commissioner Delivery | 3           | 5        | 15                                                 | We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative.  
In 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.  
Tracking overall emergency admissions activity  
Active review of schemes that are not delivering to plan and where necessary adjustments to approach made  
Where necessary bringing forward of further schemes from the pipeline to create a plan B | CCG Analytics Team                                           | Complete                                           |
<p>|    |                                                                                   |                |             |          |                                                   |                                                                                                                                                                                                                       | CCG Analytics Team                                           | Ongoing                                           |
|    |                                                                                   |                |             |          |                                                   |                                                                                                                                                                                                                       | CCG Analytics Team                                           | Monthly in time for the BCF Board.                                           |
|    |                                                                                   |                |             |          |                                                   |                                                                                                                                                                                                                       | Programme Lead                                               | As required                                                   |</p>
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Method</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Schemes increase demand for community services which cannot be met resulting in higher waiting times for assessments and service provision.</td>
<td>Delivery</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Service development plans will consider the impact on the whole pathway. Market or service development work will be undertaken to monitor the impact and take appropriate action to develop increased capacity across the system.</td>
<td>Workstream leads, BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Disruption associated with BCF schemes impacts negatively on social care related quality of life or on patient experiences of NHS services</td>
<td>Delivery Quality</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Regular performance monitoring and patient/customer feedback will be used to identify changes which require remedial action.</td>
<td>Workstream Leads</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workstream Leads, PMO BCF Board</td>
<td>Workstream Leads, PMO BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Schemes are not financially evidence-based or financially modelled adequately for full benefits realisation.</td>
<td>Financial</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A business case template has been developed and approved by the Board which requires the financial and evidence bases to be stated. Proposed schemes are pilots for specified periods of time. This will enable evidence gathering and a full evaluation to take place. Active review of schemes that are not delivering to plan and where necessary adjustments to approach made</td>
<td>Workstream Leads, PMO, BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workstream Leads, PMO, BCF Board</td>
<td>Workstream Leads, PMO, BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Full budgets are not identified to meet the additional costs resulting from the new Care Act.</td>
<td>Financial risk</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Ring-fencing the Care Act allocation in the S75. The Lincolnshire Model is being used to evaluate the likely additional costs of the Care Act.</td>
<td>Care Act Board</td>
<td>6 weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>duties or for protection of Social Care spending.</td>
<td></td>
<td></td>
<td>Care Act.</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Acute Providers will not be able to take out sufficient capacity and cost contemporaneously with the planned changes in patient flows and in line with the associate income reductions</td>
<td>Financial to Provider</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>The shift of activity from acute to community could result in the Council over spending on social care as a greater number of care packages are required</td>
<td>Financial to Council</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>A lack of capacity in primary care given rising patient numbers prevents the successful roll out of the schemes that require added primary care input</td>
<td>Delivery</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td>Full budgets are not identified to meet the cost of carers.</td>
<td>Financial to Council</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>The plan depends heavily on local partners and providers. Key providers</td>
<td>Delivery</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Failure/Failure to Deliver on their Services and Targets Put Both the BCF Plan at Risk and Potentially Also Risks Destabilising the Adult Social Care Market.</td>
<td>Performance Reports to Gain Assurance That Performance is on Track or Remedial Actions Planned.</td>
<td>Workstream Leads ERYC Brokerage Reports PMO</td>
<td>Monthly Monthly and Adhoc Reports</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>11 The Population Do Not Understand or Engage in the Change.</td>
<td>Communications Strategy in Place, Which Sets Out How We Will Communicate with All Key Stakeholders.</td>
<td>BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>12 The National Timeframe to Plan and Implement the Whole System Changes Across Health and Social Care, Including All Providers, Are Ambitious.</td>
<td>Robust Governance Arrangements Are in Place to Support Delivery, From Assessment of the Draft Template Through to On-Going Programme Overview Through the Health and Wellbeing Board. Concordat Signed by All Key Stakeholders, Evidencing Commitment to Delivery of the BCF Plan.</td>
<td>BCF Board HWB</td>
<td>Monthly 6 Weekly</td>
<td></td>
</tr>
<tr>
<td>15 Shifting of Resources to Fund New Integrated Community-Based Services May Destabilise Current</td>
<td>Acute Representation on the BCF Programme Board and Sign-Up to the BCF Plan and Concordat. The Performance Reward Grant</td>
<td>BCF Board</td>
<td>Monthly</td>
<td></td>
</tr>
</tbody>
</table>
| 15 | Organisational pressures will restrict the ability of our workforces to have the capacity to deliver the BCF workstreams, as staffing resources available are finite. | Workforce | 5 | 5 | 25 | Workforce planning and change managements are key elements of both the BCF and the Care Act.  
Early involvement of staff to ensure that they feel engaged in the design of new models.  
Creation of a flexible workforce.  
Introduction of staffing champions/leaders.  
On-going supervision and support.  
Training needs assessment to identify new skills required (if applicable).  
Maximisation of IT resources available and agile working opportunities. | BCF Board CCG Board | Monthly | BCF Board BCF Board Council Providers | Ongoing |
<p>| 16 | Delivering two significant change programmes concurrently; there are competing and conflicting demands on Adult Social Care in terms of the BCF and the Care Act. | Workforce Delivery | 5 | 4 | 20 | Workstreams are aligned and there are congruent governance arrangements to identify and address pressures. | BCF Board HWB | Monthly | BCF Board Workstream leads | Monthly 6 weekly |</p>
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Delivery</th>
<th>Status</th>
<th>Delivery Date</th>
<th>Remarks</th>
<th>Lead</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Information governance requirements are not understood and addressed adequately.</td>
<td>Delivery</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Working towards integrated IT systems and establishing/reviewing existing information sharing agreements. Information governance issues are being considered by the single shared electronic health and social care record workstream who are developing solutions. IG issues will include consideration of the consent of service users and will ensure that the information sharing protocol has been cleared by legal advisors across Health and Social Care.</td>
<td>BCF Board Workstream Leads</td>
</tr>
<tr>
<td>18</td>
<td>Integration of services, teams or budgets blurs the distinction between chargeable social care support and non-chargeable NHS services.</td>
<td>Delivery</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>A resource and infrastructure work group, including representation from legal and financial services, has been created to ensure that all issues are assessed and mitigated for.</td>
<td>BCF Board</td>
</tr>
<tr>
<td>19</td>
<td>Current IT systems do not meet all of the needs of the BCF nor support integrated working.</td>
<td>Delivery</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>IT system issues are being considered by the single shared electronic health and social care record workstream. Work is also ongoing through key suppliers.</td>
<td>BCF Board</td>
</tr>
<tr>
<td>20</td>
<td>The CCG and Local Authority do not have co-terminus boundaries.</td>
<td>Delivery</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>The Vale of York CCG has been engaged in the development of the East Riding BCF plan and will be part of the S75 agreement. They are also members of BCF Board HWB.</td>
<td>BCF Board HWB</td>
</tr>
</tbody>
</table>
both the Health and Wellbeing Board and the BCF programme Board who are responsible for the governance of the programme.

Please note: All risks on the risk register will be owned by the Resource and Infrastructure (R&I) workstream who will take on the responsibility of ensuring mitigating actions are undertaken. The timelines for resolution will be agreed between the specific project workstream and the R&I workstream lead and will be linked in to the programme plan deliverables. The R&I group will also maintain the programme’s overall risk register and will report on progress on risk resolution through the BCF programme board. The risk register has been developed in partnership with the stakeholder organisations that sit on the Programme Board; ensuring wider agreement and sign off on the risks to implementation. These organisations have also signed up to the Concordat which has commitments to ensuring:

- A ‘no surprise’ culture by maintaining dialogue.
- That risks are identified, assessed and mitigating actions agreed.
b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The ERYCCG and Local Authority have close working arrangements which ensure organisations participate in decision making and planning. Specific examples of this include:

- The ERY CCG Chief Officer is a member of the Local Authority Corporate Management Team;
- The ERY CCG Director of Commissioning and Transformation is a member of the Council Senior Management Team;
- Health and Social Care Executive Team Meetings;
- The Local Authority Director of Adult Services and Director of Public Health are members of the CCG Governing Body;
- ERY CCG Localities (geographically smaller working groups) are attended by Social Care representatives.

Partners to the BCF have agreed a single Programme Management Arrangement through the East Riding of Yorkshire Local Authority to ensure consistent understanding of the BCF programme delivery and risks. These working groups are supported by representatives from commissioners and providers including:

- Hull & East Yorkshire Hospitals NHS Trust
- Humber NHS Foundation Trust.

A risk sharing agreement with ERYC has been drafted and is based on input from both parties. Formal approval will be agreed as part of signing off the S75 legal documentation, details of which are demonstrated in principle in Appendix 2. It is anticipated that the risk share will be formalised and signed by the end of January 2015 to ensure that all parties are comfortable with the principles.

General principles are:

- BCF operates on the principles of affordability and equity to ensure a sustainable and resilient care economy;
- Organisations will act in the best interest of the overall care economy. This includes gain sharing where necessary and elimination of cost ‘shunting’;
- Changes to service, including investment and decommissioning will be based on robust evidence demonstrating net impact across organisations;
- Partners will be involved, and have representation, in the development of organisational plans including and beyond the elements contained within the BCF;
- Plans and budgetary provisions/contingencies in each area agreed by all partners at the beginning of financial year;
- Overall financial management continues to be the responsibility of individual organisations (the statutory body) and in the first instance risk will be managed by individual organisations;
• Decisions are based on the medium to long term impact not short term wins.

Operationally for 2015/16 this translates into:

• Each party to the BCF remains responsible for their historic areas of expenditure and contribution to the pooled budget;
• Financial risks, mitigation plans and contingencies are developed by the responsible organisation in conjunction with BCF partners.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Better Care is an enabler within the ERYCCG’s operational and strategic plan, as illustrated in the diagram on the next page. Other workstreams within these plans also deliver aspects of the Better Care Fund Plan including the development of Locality Hubs and Ambulatory Care. The BCF is not a programme that is run in isolation of other programmes of work being undertaken within the East Riding. The BCF provides a through line that underpins the strategies set out in the strategic plans of both the CCG and the Local Authority. The diagram overleaf shows the alignment between the wider transformational programmes across the East Riding.
### Wider System Transformation Program

#### Key Areas of work both within and outside of the BCF

- **Productive Elective Care**
  - Making our elective care services more streamlined

- **Unplanned Care**
  - Enhance Unplanned Care services and outcomes

- **Community and Primary Care**
  - Transformation and Integration

- **Better Care Fund**
  - Integration of services to provide "Better Care"

- **Vulnerable People**
  - Changing services to be more person centred

#### Key objectives

- Create headroom to enable transformational change across planned care services
- Patient treated in most appropriate environment for their condition when needing unplanned care
- Improve capacity and capability of primary, community and the wider community to enable shift of care from acute services
- Integration of services across health and social care
- Ensuring responsive and high quality services are in place to support our most vulnerable population

#### Key projects

- Adoption of best practice guidelines
- Creating Headroom:
  - Unnecessary OP follow-ups reduced
  - Daycase / Outpatient Shift maximised
  - Increase range of guidelines on Map of Medicine
  - Goole Health and Wellbeing Campus
  - Standardised service offer
- Development of Ambulatory Care models in both hospital and community settings
- Development of an unplanned care strategy
- Ensure winter emergency planning systems and processes in place
- Integrated Hospital Teams based within HRI
- Pilot Hubs
- Collaborative Falls Pathway
- Primary Care and Community Strategies completed
- Primary Care Market Development
- End of Life services improved to increase preferred place of palliation
- Primary Care Psychological Therapies (IAPT) redesign
- Development of Ambulatory Care models in both hospital and community settings
- Locality delivery networks development including single point of contact
- Increased range of prevention and self care programmes Short Term
- Assessment and Reablement Service
- Practical Home Support
- Reablement beds
- Enhanced Hospital Teams
- Supporting the Frail Elderly
- Care Homes support
- Improvements in dementia/minor cognitive impairment support
- Changes to Personal Health Budgets
- Winterbourne
- Improvements in services and outcomes for Looked After Children
- Ongoing development of services for emotional health and wellbeing
b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

There is close alignment between the Joint Health and Wellbeing Board Strategic Plan, the CCG’s operational and strategic plans and the Better Care Fund plans. As previously described the Better Care Fund Plan is seen as an enabler for the other two plans. All the plans share the same strategic aims, to:

- support our patients and population to achieve healthy independent ageing;
- reduce health inequalities across the East Riding of Yorkshire;
- improve the mental and physical health and wellbeing of children and young people and outcomes.

The following diagram taken from the ERYCCG strategic plan for 2014/2019 demonstrates ERYCCG’s five-year system overview as a ‘plan on a page’; clear links can be seen with the East Riding of Yorkshire’s planned outcomes and the delivery aims of the BCF Plan:

- Ambulatory Care;
- Care within an individual’s home or locality;
- Standardised offer of care;
- Principles, visions & values.

All the schemes in Annex 1 are an integral part of the operational plans and strategic objectives of all partner organisations.
East Riding of Yorkshire System Overview

**SYSTEM OBJECTIVES**
- Secure additional years of life for people with treatable mental / physical conditions
- Reduce avoidable time in hospital
- Increasing positive experience of care outside hospital
- Improving health related quality of life for people with LTC
- Increasing positive experience of hospital care
- Eliminating avoidable deaths

**SYSTEM CHANGE INITIATIVES**
- **Transforming Community & Primary Care / Enhanced Unplanned Care**
  - Ambulatory Care becomes principle delivery model where clinically appropriate across primary, community and hospital based settings. Delivers increased step up and step down services to deliver admission avoidance and reduced days in hospital
- **Transformation of Community Services**
  - Ensuring individuals are able to access a range of services close to home which enhance their healthcare experience
  - Single point of contact
  - Locality Hubs
- **Productive Elective Care** ensuring that:
  - Best practice applied as the norm
  - All organisations embrace and adopt innovation
- **Standardised Offer of Care** delivering accessible, quality services to all at the point of need

**SYSTEM VISION**
- Individuals take greater ownership of their own health and wellbeing
- Services are, in the main, delivered in the community by a range of providers
- Integrated health and social care through locality focused service delivery hubs
- The remit for hospital based services is clear and reflects where they can add value and expertise

**SYSTEM VALUES AND PRINCIPLES**
- Patient Centred – Quality, Safety, Patient Experience
- Partnership Working - integrate care, reduce fragmentation, increase efficiency, respect
- Transparency - Being clear on the decisions made and on the rationale for decision making
- Legitimacy - effective involvement and engagement
- Inclusivity – In engagement of groups and individuals

**SUCCESS CRITERIA:**
- Individuals and their carers at the heart of a new joined up care and support system; being cared for in their home as a matter of course.
c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The East Riding of Yorkshire CCG has been accepted to co-commission primary care services across three elements:

1. working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
2. design local contracts/enhanced services commissioned by NHS England where this fits with the CCG priorities (not GMS, PMS or APMS);
3. deciding in what circumstances to bring in new providers and advising on practice mergers.

The CCG believes that new arrangements for co-commissioning will enhance the planned developments across primary, community and social care in the East Riding, which would support the implementation of the CCG’s strategic priorities. These arrangements will help with the delivery of the BCF plan, particularly in regard to the design of local contract and enhanced services. Effective joint working with the Health and Wellbeing Board will ensure the alignment of strategic priorities to support the delivery of locally designed integrated services.

We also believe that by working with the Area Team to develop a more consistent offer of primary care services that are accessible, proactive and co-ordinated will enable improved partnership working with all of our providers, alongside a better understanding and use of services by the patients.

The Community Care Strategy is a blueprint for the future delivery of the services required to meet the needs of the local population now and into the future. It describes the vision for:

“A truly integrated health and social care economy that delivers consistent, systematic good quality community care by the right person, in the right place, at the right time whilst ensuring the long-term sustainability of the NHS in the East Riding.”

This multi-agency approach, involving health, social care and the wider community will be delivered through a patient centred model. It will be based around natural local communities and spans a range of services from individualised care for complex individuals, with a rapid response at a time of crisis, through proactive, planned care based around the patient’s own priorities, and an underpinning emphasis on active self-management, supported by information and access to a range of community based, community run initiatives.

The CCG sees General Practice as being the cornerstone to build these services around. Co-commissioning is therefore an integral enabler for the CCG to achieve its strategic aims; with primary care a key driver in designing the community strategy.

The CCG has a well-established Primary Care Development Group (PCDG) with patient, GP, practice manager, LMC and Area Team representation that is driving forward an
action plan to support primary care transformation locally. This, alongside the Locality Structure that exists in the CCG, allows primary care providers to be engaged in many different ways within the CCG. The plans for the Better Care Fund have been discussed at these forums and has widespread support from primary care.

The key risk for primary care in terms of reducing secondary care activity is the workforce capacity due to the ageing workforce and difficulties recruiting to this area. Whilst linked in with the BCF risks (risk 12 in section 5) this is seen more as an organisational risk rather than BCF specific. To mitigate this, the PCDG is leading on several initiatives:

1. A recruitment event in partnership with Hull Business School to fund an Executive MBA for aspiring GPs to encourage recruitment to the East Riding.
2. A bursary for nurses in primary care to build capacity to allow an increased number of student placements in primary care.
3. Supporting the development of an Academic Hub in a locality with Hull and York Medical School.
4. Supporting several practices to complete the Productive General Practice Programme to improve quality and capacity.
5. Working closely with the local Universities to develop a mentoring and leadership programme for clinicians to support retention on qualification.
7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting adult social care services in the East Riding of Yorkshire means ensuring that those most in need within our local communities continue to receive support, in a time of growing demand and budgetary pressures.

The Care Act includes a national Fair Access to Care Services (FACS) eligibility criteria that will have to be complied with. The impact of this should not be underestimated as it is likely to lead to more people being eligible for public-sector funded care. The Care Act will also promote a new asset based model of social work and duties for prevention and early intervention. However, the focus continues to be on looking at new models of integrated care and enhancing the quality of care by tackling the determinants of both ill-health and poor quality of life, rather than focusing on the supply of services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Reablement services form a key element of the Intermediate Tier Services continuum. Intermediate Tier Services aim to support people with health and social care needs to stay in their own home rather than being admitted to hospital or into long term care. They provide support to people when they are discharged from hospital, help people to remain independent and help to identify any ongoing needs. Access to Intermediate tier services is for anyone aged 18 and over, who is a resident of the East Riding and needs short term health, therapy and support to regain their independence and or to rebuild confidence. The range of intermediate tier services available across health and social care in the East Riding, includes intermediate care beds, intermediate care at home and a number of reablement services (as detailed below). Services are accessed through the ERYC Single Intake and Duty Team, which receive referrals for intermediate care, reablement and wider adult social care support.

A council wide programme of transformation has been in place systematically reviewing all services since 2011. Adult Social Care was set a target of achieving £4.7m from identifying and maximising efficiencies and effectiveness of services. Reviews to date have released in excess of £3m and plans are in place to deliver the remainder over the next two years. This has allowed savings to be allocated to a specific reserve to support the demographic pressures on the service.

Funding currently allocated via health to social care has been used to provide a contribution towards enabling the Local Authority to sustain the current level of FACS eligibility criteria through:
**Integrated and Enhanced Hospital Teams**
Adult Social Care (ASC) and Health established an Integrated Hospital Team, which operates a seven day service, within Hull Royal Infirmary. The team deliver a comprehensive early assessment service to reduce hospital admissions from A&E, promote timely discharges from other wards, and identify patients who would be suitable for intermediate care and/or have short term reablement potential. Additionally, ASC also have Enhanced Hospital Teams supporting other key acute/community hospitals, which service East Riding residents. Whilst these teams are not integrated with health, they work closely with health colleagues. Currently the teams provide a five day a week service and operational resilience bids have been submitted to increase to seven day working in two of the key teams.

**Reablement beds in Pocklington and Bridlington**
ASC currently operate six (in-house) reablement beds in the East Riding, with the ability to flex up to twelve beds, during periods of peak demand. These beds are supported by experienced care staff, with access to occupational therapy assessments, support, equipment, advice and home visits. Reablement beds are utilised to support people to be discharged from hospital in a timely manner, where they have short-term reablement potential, and also to prevent unnecessary admissions to hospital, where the service user is medically stable. In addition to reablement beds, a bid has also been submitted for operational resilience funding to purchase four ‘Time to Think’ beds in the Haltemprice area and a further three in the Bridlington area. The aim of these beds is to increase acute bed capacity by allowing the assessment and sourcing of a residential placement or care package to take place away from the acute setting for individuals who are MDT fit, over the acute phase of their illness and safe to be discharged into the care of a GP.

**Short-term assessment and reablement services (STARS)**
The STARS service operates between 7am and 10pm, seven days a week. STARS provides a short-term service to support people to maximise their independence by learning or re-learning the skills necessary for daily living e.g. getting dressed, washed, making a meal. The service assesses individual needs, agrees a reablement support plan, provides practical and emotional support to improve confidence with daily living skills, works with individuals so they can return home - or remain at home - and arranges delivery of small items of equipment to support independence.

**Practical Home Support Service (PHS)**
The PHS Service operates 24 hours a day, seven days a week to prevent unnecessary hospital admissions and to support timely hospital discharges. The short-term service operates for up to 72 hours to undertake basic tasks to support someone at home e.g. ensuring the heating is on, undertaking shopping, settling a person back home etc. The team also have access to provide 24/7 lifeline telecare installations, pending full telecare assessments and can also access small items of equipment such as foldable commodes etc. Joint working with the Yorkshire Ambulance Service (YAS) has resulted in the creation of a referral pathway to the PHS. This supports referrals from paramedics whilst responding to emergency calls, which do not require admission to hospital, but which do require further intervention to provide reassurance and support to enable an individual to remain at home.
Additionally, an operational resilience bid has been submitted to expand this service to provide a crisis support service to cover the Bridlington area. This pilot could provide support to patients for a short period of time, until family or alternative social care support can be established e.g. overnight sitting service, personal care and onward referral to other services.

- **Telecare (six weeks free reablement)**

  The East Riding Lifeline Telecare Service provides a range of telecare (alarms and sensors e.g. personal trigger, falls detector, smoke detector) in the home, which can help to support independent living. The alarms are linked to a call centre, which provides 24-hour cover, 365 days a year. Under reablement, the service is provided free for a period of six weeks. Telecare equipment forms part of the adult social care assessment process and can be used to meet assessed needs. Individuals who do not meet the FACS eligibility criteria can purchase telecare support direct from Lifeline.

  Agreement has been reached for 2014/15, which is also essential to support the thrust of the Care Act; which requires additional assessments to be undertaken for people who did not previously access social care services.

  It is recognised that reducing admissions and supporting timely discharges will also place additional pressures on adult social care and this will be monitored in the risk register by the Resource and Infrastructure Work Stream and reported to the BCF Board. The Market Position Statement produced by the council looks forward and projects potential gaps and increased demand for service in order to alert the independent and third sector providers to potential opportunities for service development.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The protection of adult social care services is limited to the existing £6.627m NHS Transfer, the vast majority of which is committed to maintaining ongoing service spend. The local proportion of the national £135m for the new Care Act equates to £0.8m which has also been identified from within the NHS Transfer resources, i.e. not from the £1.9bn from the NHS in 2015-16 that is additional to the BCF.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

We have established a local Care Act Executive Board which is a senior level decision making body, comprising Health and Adult Social Care managers. The Board has identified a number of ‘workstreams’ with identified leads to respond to the main duties of the Act. These workstreams are:

- integration;
- assessments, eligibility, care, support planning and provision;
• carers;
• information and systems;
• workforce development;
• prevention, information and advice.

Each workstream has lead officers that attend the Board and workstream leads have separate meetings with their sub-groups. Sub-groups comprise of staff from across health and social care sectors, as well as voluntary agencies. The Care Act Board and additional workstreams have been established so that we can respond quickly and appropriately to changing circumstances and be able to provide both support and challenge, as required. The Care Act Board meets on a six-weekly basis.

We have also established a local Stakeholder Group, chaired by the Portfolio holder for Adult and Carer services. The main purpose of this group is to discuss any issues relating to implementation of the Act, to receive and disseminate information across all relevant partners and sectors, and to contribute to both driving and supporting culture change. This group meets on a quarterly basis.

We continue to attend regionally established meetings to ensure that, when appropriate, issues can be addressed and discussed at Regional level. This has been established with the Association of Directors of Adult Social Care (ADASS) for the Yorkshire and Humber region. Key staff from within the Local Authority that sit on these groups also attend the BCF Programme Board and have roles within the BCF workstream groups too. Additionally, staff from the CCG also sits on the Care Act Executive Board and the Chief Officers of the key stakeholder organisations meet on a monthly basis to discuss the implications of the BCF and the Care Act. These cross-cover arrangements ensure that the links between the organisations and the work to implement the requirements of the Care Act and the implementation of the BCF plan are maintained.

v) Please specify the level of resource that will be dedicated to carer-specific support

ERYC currently spend in excess of £1m on carer specific support which includes circa:

• £305k on the cost of Carer Support staff/buildings to provide carers assessments, support, advice and information;
• £325k on carer relief services including providing a sitting service, emergency breaks etc;
• £41k on carers regional breaks;
• £378k on the cost of carers direct payments;

In addition to the monies dedicated by ERYC, the VoYCCG and ERYCCGs also contribute a sum totalling £50,000 to support carers’ services in the East Riding.

The chair of the Carer’s Advisory Group sits on the BCF programme board ensuring that the implications to carers are considered during the development of the BCF plan. However the programme board have recognised that there is additional work to be done in relation to carer support and are committed to raising the importance of this as the detailed plan is created.
vi) Please explain to what extent has the local authority’s budget been affected against what was originally forecast with the original BCF plan?

The local authority's adult social care budget is not directly affected by this Plan or the Better Care Fund Plan submitted in April 2014. Existing funding of the adult social care budget by the NHS Transfer continues, as stated in iii) above, but a significant funding gap remains within ERYC’s financial envelope, which is caused by increasing demand and cuts in government funding. This is being managed in the short term with one-off funding. Efforts to prevent people unnecessarily going into hospital and to support timely discharges will increase the pressure on local authority services.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Working with our providers we are committed to the further development of seven day services to support the move to the new ambulatory care model. This integrated approach will ensure the delivery of timely assessments and appropriate levels of access to services 365 days a year, to prevent admissions and to support discharges.

We currently operate a number of seven day services within adult social care, which include the Short Term Assessment and Reablement Services (STARS), Practical Home Support Service (PHS), Reablement Beds and Telecare (Lifeline)/response service, in addition to our Emergency Duty Team (EDT), which provides an out of hours urgent/crisis response for Adult Social Care. These services have been developed to prevent unnecessary admission and to support early discharge from hospital.

We also have seven day working as part of an Integrated Health and Social Care Team within Hull Royal Infirmary to prevent admissions and support discharges. However, residents of the East Riding are also admitted/ transferred to other campuses for Hull and East Yorkshire Hospitals and also to other acute providers, which are out of county. Thus, as part of the operational resilience process, we have secured funding to establish seven day working (Social Workers) at Castle Hill Hospital and also at Scarborough Hospital (York Hospital Teaching Trust). Additionally, funding has been agreed to provide seven day working within the Council’s Occupational Therapy Team to further support discharges, prevent avoidable admissions and ensure a smooth transition home from acute beds or into reablement services.

As the programme plan is reviewed a process for agreeing the actions with providers to deliver the clinical standards for 7 day services will be created. Providers that sit on the program board are aware that this is the direction to travel and are bought into the principle of seven day provision. The pilot of the Goole, Howdeshire and West Wolds Frailty Support Service is a seven day service; the appraisal of this service will enable us to assess where seven days service should be targeted to achieve the best results prior to the wider roll out of the service model.
c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health services use the NHS patient number as the primary identifier. Our NHS contracts specify the use of the NHS number and associated financial penalties for not doing so.

Currently Social Care services within the East Riding do not use the NHS patient number; a working group has identified the methods for applying the NHS number within the Social Care System. Tests on the preferred method will take place later in the calendar year to allow full matching of patients by early 2015.

The commitment to data sharing, and working towards the use of the NHS patient number as the primary identifier, is a key principle of the Better Care Fund Concordat.

Development of the single shared electronic health and social care record will be based on using the NHS number. The project group has been established under the remit of the Resource and Infrastructure work stream the aim being to implement the shared system by 2018. Interim processes to enable the appropriate sharing of information will be developed to bridge the gap between now and 2018.

A working group has also been set up, as part of the Better Care Fund programme which will look at how case management and care coordination can be conducted in a multi-agency approach with appropriate data sharing procedures in place. The vision is that patients and carers should only have to tell their story once. Records should travel with the patient and be relevant to their care pathway. The use of one personally identifiable number is central to this vision.

The Local Authority’s system has the functionality to store the NHS number and as a result we are looking at recording the patient’s NHS number in order to assist with data sharing. We are currently looking at social care practice and process in line with the Care Act and as a result, changes will be made to social care practice, systems and processes. Work is ongoing with amending assessments for clients and carers and the NHS number will be incorporated into all paperwork along with our ‘first point of contact’ (Single Intake and Duty team) in order to record the NHS number within social care.

This will assist with data sharing in the short term and we will continue to work towards the use of the NHS patient number.
ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)).

Our approach to implement open APIs and ITK is based upon the provision of an Humber region wide Health and Well-being hub. This was submitted as a bid for the integrated digital care record fund on behalf of the following organisations:

- City Health Care Partnership
- East Riding of Yorkshire CCG
- East Riding of Yorkshire Council
- Hull City Council
- Hull CCG
- Hull & East Yorkshire NHS Trust
- Humberside Fire & Rescue
- Humberside Police
- Humber HHS Foundation Trust
- North East Lincolnshire CCG
- North East Lincolnshire Council
- North Lincolnshire & Goole NHS Foundation Trust
- North Lincolnshire CCG
- North Lincolnshire Council
- North Yorkshire and Humber Commissioning Support Unit
- Yorkshire Ambulance Service

We have been interviewed and awaiting a response from the Treasury.

The aim of the Health and Wellbeing Hub is to provide a regional ‘Virtual Care Record’ across North and South Bank providers covering a range of care provision. We expect the Hub to unify information flows from different feeder systems and enable better access and synchronisation of provider records.

The core components of the Hub will include:
- Regional Enterprise Master Patient Index (eMPI) and ‘Virtual Care Record’
- Service Bus architecture using integration technology and standards to process, apply, respond and synchronise feeder systems
- Web based portal(s) for providers without compliant systems and patient access to their individual record

The Health and Welling Hub would include a Service Bus and act a brokerage service between Sending and Receiving systems. Local provider systems would include but not be limited to:

- Lorenzo
- Web V
- CareFirst
It is expected that significant message volumes will be processed on a daily basis, requiring infrastructure and software architecture. Exact quantities are currently unknown.

This is based on the architecture in the two diagrams below;
The ITKs will the specification detailed at by the Health and Social Care Information Centre (HSCIC) http://systems.hscic.gov.uk/interop/background

Project delivery approach

This project is already in flight and has been endorsed by the major health and social care change programmes in the Humber area:

- Hull 2020
- East Riding of Yorkshire Better Care Fund
- North & North East Lincolnshire Healthy Lives, Healthy Futures

The project will be broken into key phases as follows:

Establish Project Structure, Team and Plan: This is not a single organisation project. A Project Board with representation from all partner organisations will be established and a dedicated Project Team will be appointed for the lifetime of the project to work alongside the chosen technical partners. Clinical leadership and expertise will be embedded in the overall governance framework, which will be in place by October 2014.

Scoping Phase: Our vision is to create a feature-rich, unified record from systems already in use across partner organisations; the Unified Health & Well-Being Hub will overlay, not replace, those existing systems. A standards-based framework and roadmap will be created for this development. The first stage therefore will be to create an output based specification which reflects current systems and information flows, how that supports the clinical development pathways that have been initiated under the three distinct programmes and is agile enough to accommodate future needs and systems changes, and changes in commissioned services.

Procurement and Supplier Selection: We will issue the output based specification and tender documentation. We expect to utilise existing frameworks (eg G-Cloud) based on guidance from the organisations’ procurement experts. We will carry out a due diligence assessment and select the supplier.

Proof of Concept Phase: This phase will consist of building the core product and proving the system integration, messaging, access control and user experience components. We will select representative primary key information systems to be interfaced in this phase (eg Pathology, EPR, Child Health, GP, Social Care). This phase will address the complexities around IG, access control, information sharing, etc. This phase of work culminates in design sign-off and clinical/user assurance acceptance.

Operational Access: This phase will extend the Hub to incorporate all relevant feeder systems over time, with further roll out to other agencies supporting patient care.

Patient Access: The roll-out of patient access will be based around patients with long-term conditions and/or complex social care needs. This will then be expanded upon over time. It is envisaged that this will run concurrently with the operational access phase.
The plan to implement the hub is shown below;

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-14</td>
<td></td>
</tr>
<tr>
<td>Sep-14</td>
<td>Step-up programme team for development</td>
</tr>
<tr>
<td>Oct-14</td>
<td></td>
</tr>
<tr>
<td>Nov-14</td>
<td>Carry out outline business change for the new ways of working using the solution to inform the specification.</td>
</tr>
<tr>
<td>Dec-14</td>
<td></td>
</tr>
<tr>
<td>Jan-15</td>
<td>Create a business case for the solution</td>
</tr>
<tr>
<td>Feb-15</td>
<td>Complete output based specification and tender documentation</td>
</tr>
<tr>
<td>Mar-15</td>
<td>Issue tender</td>
</tr>
<tr>
<td>Apr-15</td>
<td>Carry out preparation work for ITK with proof of concept systems</td>
</tr>
<tr>
<td>May-15</td>
<td>Achieve 95% NHS number matching with Local authority systems</td>
</tr>
<tr>
<td>Jun-15</td>
<td></td>
</tr>
<tr>
<td>Jul-15</td>
<td>Carry out evaluation of final tenders</td>
</tr>
<tr>
<td>Aug-15</td>
<td>Award contract for solution</td>
</tr>
<tr>
<td>Sep-15</td>
<td></td>
</tr>
<tr>
<td>Oct-15</td>
<td>Core product build ready for Proof of Concept Phase</td>
</tr>
<tr>
<td>Nov-15</td>
<td>Start Proof of concept phase</td>
</tr>
<tr>
<td>Dec-15</td>
<td></td>
</tr>
<tr>
<td>Jan-16</td>
<td></td>
</tr>
</tbody>
</table>

To ensure we provide the Unified Health and Well-Being Hub’s safety, we will be using a supplier that is fully compliant with ISB 0129 Clinical Risk Management: its Application in the Manufacture of Health IT Systems, and the partners will fully comply with ISB 0160 Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems.

If the bid is not successful the partners are still committed to the creation of the unified health and Well-being hub, but it we would expect it to take longer to develop and implement.
Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

All integrated services will be delivered within the requirements of our Information Governance framework as detailed in the following policies:

- Caldicott & Data Protection Policy (copy attached)
- Code of Conduct on Confidentiality and Information Security Policy
- Confidentiality Audit Policy
- Access to Records Protocol (including medical records)
- E.R.Y.C. Data Protection Policy
- E.R.Y.C. Handling Personal Data Guidance
- E.R.Y.C. Data Protection Requests/Process Guidance

Humber Information Sharing Charter and in line with Caldicott 2.

We are committed to ensuring that patient confidentiality is maintained.

Specifically all health projects will be managed within these rules and Patient Confidential Data will only be used by clinicians. All project level reporting will be on high level, non-Patient Identifiable data. All staff are required to complete IG training annually.

All stakeholder organisations use either NHS mail or GSI, both of which are secure e-mail services.
d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The Risk Stratification tool was used in GP Practices to identify the 2% of their practice population at greatest risk of hospital admission. 100% of GP practices across the East riding have signed up to Avoiding Unplanned Admissions Enhanced Service Proactive Case Finding. The aims of the Enhanced Service are:-

- Putting in place a system for patients to be included on a register to receive same day telephone consultations when they have urgent enquiries
- Named accountable GP and Care Coordinator for the top 2% as identified through their risk stratification
- Care Plans are in place for this patient cohort

The CCG is currently working with practices, community services and social services to develop locality approaches to integrated community care, for example:

In the Goole, Howden & West Wolds Locality Hub rapid response pilot, the use of the risk stratification tool was supplemented by multi-disciplinary discussions involving general practice, community services and social care, to ensure that all high risk / complex patients / service users known to the teams were included. These discussions highlighted that a significant proportion of these patients were not known to social care services.

Across the East Riding, Health-Numerics-RISC is used; this is a risk stratification tool that identifies patients who would benefit from preventative care. Health-Numerics-RISC also provides information on the health need of a population allowing effective design and configuration of healthcare services. Through integrating multiple data sources including GP episodes and medications with acute care, high risk patients are accurately identified for case management.

It is recognised nationally that patients with a long term condition account for more than 50% of all GP appointments; 65% of all outpatient appointments; over 70% of all inpatient bed days. To identify this cohort of patients the CCG has commissioned a Long Term Conditions Clinic through GP practices across the East Riding to identify patients with 2 or more LTCs from an agreed list. The objective of the clinics is to standardise an approach to the development and delivery of clinics for patients with LTCs and increase the confidence and competence of patients to self-manage and share the care of their condition. The process is multi-disciplinary and multi-agency ensuring appropriate input from and signposting to health and social care to meet the specific needs of the individual patients.

The CCG has commissioned a Mild Cognitive Impairment Assessment and Review Service from GP practices. The aim of the service is to deliver early diagnosis of MCI and to establish a reviewing process to monitor the development of cognitive impairment. Patients diagnosed with MCI should be communicated in a person-centred way to both the person with MCI and their carers supporting patients and carers as necessary. Patients with a positive diagnosis will have an agreed action plan in place with suitable advice about optimising physical health including treatment for risk factors for dementia (control hypertension and diabetes).
ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

In the Goole, Howden & West Wolds Locality Hub rapid response pilot, the individuals who are identified as being part of the 2% cohort will have a holistic assessment contributed to by all relevant members of the MDT, including social care representatives, along with an individualised care plan. These individuals will be given a single point of access contact number, which will take them through to a healthcare co-coordinator (a senior clinician) who will be able to triage and clinically assess their needs, and will action this as required.

The learning from the Locality Hub pilot will be used to shape the roll out of this approach across the remainder of the East Riding of Yorkshire, if it evaluates positively.

Across the East Riding, the Intermediate Care Services are jointly delivered in an integrated way between health (community services) and social care; in areas of good practice the health and social care professional’s work together to deliver seamless services working to jointly developed care plans.

Lead professionals are identified for patients with complex needs, such as those with multiple long term conditions who have a named Community Matron, to oversee, co-ordinate and deliver their care.

As described in i) above the LTC clinics are multi-disciplinary and multi-agency to support people with multiple LTCs to enable them to achieve and maintain the best possible quality of life with their conditions.

The Mild Cognitive Impairment Assessment and Review Service is delivered in primary care with links into Memory Assessment Service. Patients with a positive diagnosis will have an agreed action plan in place with suitable advice about optimising physical health including treatment for risk factors for dementia (control hypertension and diabetes).

iii) Please state what proportion of individuals at high risk already has a joint care plan in place.

There are a number of routes through which individuals may gain a joint care plan including:

- All our intermediate care patients have a multi-disciplinary care plan, but these care plans do not currently involve Primary Care
- Our known end of life patients have joint care planning across primary care, social care and community services. They care plans do not specifically include specialist palliation but these needs are taken into consideration

Under the Unplanned Admissions Enhanced Service all patients identified as being part of the 2% cohort must have a care plan, however this differs from the existing care plans which some patients may have in place (see below); advice has been sought from NHS England to clarify whether the existing care plans would suffice, and the response was that the Enhanced Service care plan template must be used.
The actual proportion of individuals at high risk with a joint care plan in place is not known. It is possible to run reports at practice level as the 2% cohort will be Read Coded and once the care plan is in place, this too will be coded. Care plans issued as part of the long term conditions (LTC) clinics (see below) are also Read Coded, so again it should be possible to run a report to identify the proportion of the 2% with an existing (LTC) care plan.

Personal Care Plans have been in use for several years, initiated by the Community Matrons in the Community Services; these “yellow folders” contain details of the individual’s medical history, assessment, treatment plan and medication. These folders are held by the patients and are referred to and should be used by all health and care professionals involved in the care of the individual, including, if required the ambulance service.

The yellow folders / care plans have more recently been used in General Practice in the Long Term Conditions Clinics, for patients identified with two or more of a range of long term conditions, including diabetes, COPD, stroke, dementia, hypertension. As patients have been invited in for a holistic review of their conditions and medication, a personal care plan is developed, and held by the patient.

Individuals in receipt of social care services will also have a social care assessment and support plan.

As part of the Goole, Howden and West Wolds Locality Hub Pilot, work is being prioritised to develop a joint care plan, and initial plans are that the Unplanned Admissions Enhanced Services care plan template will form part of this document.
8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Our vision is for individuals and their carers to be placed at the heart of a joined up care and support system, which places their home as the default setting for care. This vision is based on what people told us is important to them. To inform the drafting of the Better Care Fund Plan we gathered opinion through a range of engagement opportunities, including:

- workshops – with representation from a range of organisations and groups including the East Riding Voluntary Action Service, Age UK, the Carers Advisory Group, Healthwatch and East Riding Health Forum;
- presentations at key partnership boards such as Learning Disability and Mental Health Boards;
- insight polling – gathering 1,150 peoples’ views about integrated services. This included seeking opinion on:
  - single point for access to services;
  - access to seven day services to prevent admissions and support timely discharge;
  - service preferences for inclusion within community hubs;
  - access to advice and information to support independence;
  - requirements for end of life support;
  - identifying opportunities to reduce duplication and delays in assessment and access to services.
- Disability Advisory and Monitoring Group and East Riding Equality Network meeting liaison. These forums represent many of the diverse groups within the East Riding with protected characteristics. We have discussed our BCF plan and engagement approach with these groups and will continue to liaise with them.

Feedback from patient, service user and public engagement has been and will continue to be used to inform and refine developments of the ambulatory care model and, in particular, the pilot locality hub and the work of the supporting programme workstreams. Continued engagement with key groups will include representation on the BCF Programme Board.

From the information gathered we know that what people want is for their care to be built around their needs and provided at home or as close to home as possible. To ensure ongoing patient, carer, service user and public engagement we are developing a robust Communications and Engagement Strategy, directly linked to that of the Health and Wellbeing Board, that includes detailed action plans for each of the workstreams as well as the following overarching aims and key messages:

Aims

- Raise awareness and understanding of the work being done to join up health and social care services (using plain language and real life case studies wherever possible). We will achieve this by explaining the situation now, why health and social
care is changing, what the benefits are, how the changes will affect people, what people need to do, the timescales for change and presenting a picture of what health and social care will be like in the future.

- To ensure that people are involved in any changes that may affect them or have an interest in (co-design). We will do this through a range of methods such as events, focus groups, surveys, world cafés, etc.

- Promote independent living, healthy lifestyles and social inclusion to help achieve the aims of the Better Care Fund. We will achieve this by publicising the initiatives and changes to services the council and its partners will be carrying out and encouraging the public regarding behaviour change.

- That the public are aware of the importance of using facilities correctly, such as A&E and MIU.

Where possible, messages will be tailored to make them specifically appropriate to partners, stakeholders and the public. Real examples and stories about people will be used to bring the messages to life. Use of video case studies will also be developed to demonstrate how changes could or have improved patients’ lives and helped them maintain or increase their independence.

We can use Customer Insight with Experian data to create customer journey mapping and identify Circles of Need to help campaigns to influence behaviour change and reduce people’s dependence on the public sector. The Experian data indicators cover hospital admissions, community transport, etc. The importance of using facilities correctly, such as A&E and MIU, will be stressed in publicity.

**Better Care Fund Key Messages**

As a health and care community we are committed to the principles and practice of co-design of integrated services through engagement and involvement of East Riding of Yorkshire residents. This is reflected in our objectives, plans, services and outcomes generated.

We will be consistent in our messages to stakeholders and we will focus on the following areas.

The personal message…
- Prevention is better than cure.
- Live longer, live better.

Regarding the need for change…
- There is a need for change because the NHS is more than 60 years old, life expectancies are longer now and the current system is unaffordable because of the increasing costs of care and reduced public sector funding.
- A more joined up approach to health and social care will make providers and commissioners more able to afford to help the people who most need services.

Why health and social care needs to be joined up better…
- Transforming health and social care will improve people’s lives by providing them with
more joined-up care to be able to stay in their own homes longer and out of hospital.

- Health care is sometimes better for the people being treated if it is not hospital-based and investing in high-quality services for the home and community can enable more of this approach.
- Health and social care services will be joined up around residents and their families and will be simpler to understand and deal with.
- Health and social care will be more pro-active and forward planned, with more early intervention reducing the need for urgent, emergency help.
- Measuring success will be more about health outcomes for people and not just about numbers treated.
- Services in the community will help people to be healthy and support them if they are lonely.

What it means for patients and their families...

- There will be a focus on looking after the whole person, not separate conditions.
- There will be a focus on putting patients and their families in charge, with self-management and shared decision-making and by helping people to keep themselves healthier.
- Where possible, care will be provided in the home or community.
- When you do need hospital care, it will still be available to you.

The plan also targets other key stakeholders including:

- East Riding of Yorkshire Clinical Commissioning Group Staff
- East Riding of Yorkshire Council Staff
- Humber Foundation Trust Staff
- Vale of York Clinical Commissioning Group (Pocklington)
- GP Federations
- Independent domiciliary and residential care providers and their staff
- Voluntary and community organisations
- MPs / Councillors
- Health, Care and Wellbeing Overview and Scrutiny Committee
- Healthwatch ERY
- Diverse groups / communities
- Patient Representative Groups (GP Practices)
- Local Authority Community Partnerships

On an on-going basis the BCF programme board continues to have representation from Healthwatch, the carer's advisory group and the East Riding voluntary and community sector steering group at all its meetings.

You said we did

*Insight polling* – we have sought the views through a telephone and website poll of 1,150 local residents who are demographically representative of the East Riding about what health and social care might look like in the future and to help us to understand what matters to local people as we plan services.

Feedback from this survey indicated that General Practice is central to future service planning as it is regarded as a trusted, local and reliable point of contact
for health care needs:

86% chose GP practice services as the top services to be available at the weekend, with minor injuries services coming second (66%)
77% chose GP practice services as the most preferred alternative to A&E admission, with minor injury services being the top choice at 83%
68% chose the GP practice as the preferred location for community hub services
60% chose the GP practice as the preferred option for receiving information to stay healthy
55% chose the GP practice as the most preferred option as an alternative to reduce hospital admission or visits
55% chose the GP as the preferred way to become actively involved in discussions about end of life care at an early stage
44% chose the GP practice as the preferred option for providing support to older people to help them maintain independence and remain healthy at home. This was followed closely by social care and voluntary service support such as befriending and meals on wheels (40%)

A preference was also often expressed for voice based contact (e.g. telephone and skype) as a method of communication about healthcare services:
80% chose voice based contact as the preferred alternative to a face to face follow up after a hospital procedure
71% chose voice based contact as the most preferred option for a Single Point of Access to services
44% chose a telephone helpline as the preferred option for providing support to older people to help them maintain independence and remain healthy at home, making this the second most popular choice

You said we did - Feedback from this survey has helped to shape this Plan.

Urgent care events – we recently held two events to listen to patient stories and seek the views of patients and their family/carers about what currently works well and what doesn’t work so well with unplanned care services.

Some of the major themes that have been highlighted as valuable by our communities in response to this engagement activity are:

- Quality and patient centred care.
- Accessibility in the method used to contact services (such as a single point of access).
- Accessibility in terms of where services are delivered, using alternative providers and facilities to keep things within local communities.
- Flexibility in terms of when services are delivered to fit in with busy modern lifestyles.
- Services to promote patient independence and preventative services to encourage healthier lifestyles.
- Services working in partnership to deliver care seamlessly.
- Being inclusive of groups with alternative or diverse needs such as migrant communities.

You said we did - Feedback from these Urgent Care events will help us to make the urgent Care Strategy more patient friendly, with particular consideration to access to
services, opening times and their location.

**Better Care** – we held this event in partnership with East Riding of Yorkshire County Council to explore the potential for greater integration between health, social care and other agencies to improve the services provided to the population of the East Riding of Yorkshire.

The key themes that were raised at this event included:

- There is already excellent work going on such as the Single Point of Access project, the Integrated Hospital Team and the reablement service. The development of a formal integration agenda should not lead to “throwing the baby out with the bath water”. It is vital that this work be able to continue through to completion.
- An assessment of innovative integration practice going on elsewhere should be seen as an on-going process, and be incorporated into the East Riding where appropriate and practical. Examples of this included:
  - A single assessment process between health and social care underpinned by an appropriate shared assessment tool or record, such as EASYCare, is essential.
  - The possible introduction of care navigators/coordinators.
  - The introduction of appropriate seven day health, social care and wider council services to help prevent acute hospital attendances and to facilitate earlier discharge.
- Support infrastructure, such as IT and data sharing, should enable integration and not be a barrier to it.
- The financial implications of integrated service redesign needs to be assessed to ensure that financial risks to organisations are properly mitigated.
- Service redesign needs to be inclusive with patients, carers, clients and other stakeholders, involved at an early stage.
- Organisations need to be ‘brave’. Traditional approaches to service delivery, staffing, budget management, procurement and commissioning should be assessed within the context of the integration agenda to ensure that they are robustly delivered.

**You said we did** – Feedback from this event has helped to shape this Plan.

**Diverse groups and carers** – Feedback and advice from the Disability Advisory Monitoring Group and East Riding Equalities Network focuses particularly on accessibility, concerns with services and equality objectives. Feedback from the Carer’s Advisory Group focuses on the carer perspective.

Key themes that have been raised recently include:

*What do you need to be central, informed and empowered to co-produce solutions?*

- Encourage patients/carers and staff to question and challenge.
- Ensure patients/carers get feedback on care/treatment/outcomes.
- Ensure Healthwatch is active.

*What do you need to be able to improve your own health and wellbeing?*

- People need to take responsibility to change their own behaviour.
- Create an appetite for it to happen by showing people how it directly affects them.
• Promote Health Checks.
• Disabled sports – need assistance with transport in this rural area.
• GP practices should have height adjustable chairs and benches to avoid home visits to disabled people.

Where to you think health can work better with social care?
• Dynamic leadership to take risks and run with it.
• Good neighbourhood care teams with well-trained multi-disciplinary staff.
• Neurological support – acquired brain injury.
• Use Healthtrainers to help get people healthier.
• Increased social prescribing, using community groups to help.
• Dementia friendly communities.
• LGBT people in rural areas often feel very isolated due to higher visibility and recognition as someone who is LGBT – give support.
• EREN raised concerns about pressures on domiciliary care services to deliver this model. The CCG/Council as agreed the skilling up carers is a key issue.

You said we did – Feedback from these groups continues to be used to influence the development of the workstreams.

Caring for Each Other - we held an event in partnership with East Riding of Yorkshire County Council where we asked stakeholders to consider ways that we could improve the care and promote better independence for people with long term conditions.

Healthy Lives, Healthy Futures for Goole - we have been working with Northern Lincolnshire and Goole Hospitals NHS Trust to review services at Goole and District Hospital to ensure we offer clinically safe, sustainable and affordable services well into the future.

At the outset of this work we established and now hold regular Stakeholder Liaison Meetings which brings together local members of the public, patients, carers, commissioners, providers, local authority and the voluntary sector.

You said we did – This group has helped to identify local health needs and aspirations and helped to make decisions around health priorities and strategies. The group developed the evaluation criteria to be used to evaluate different health care options and continue to contribute to service redesign and improvement especially with regard to defining and refining the proposed local Health Campus Model and associated work streams.

We are continuing to engage with the population of Goole and the surrounding area on proposals for the future of Goole Hospital. Our Stakeholder Liaison Group has developed the evaluation criteria for this review. They have also helped to formulate ideas for services that could be provided in the future from the Goole Hospital site. They have particularly supported the introduction of a ‘health campus’ model which offers access to wider wellbeing services provided by health, social care, voluntary and private sector. The East Riding Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has supported and also praised our engagement methods for this project.
To coincide with **Self Care Week 2014** – we held roadshows in November and December where we visited various locations on our patch and talked to people about self-care, offering advice and asking for views.

We conducted a **review of Working Age Adult Mental Health Inpatient Services** in partnership with Humber NHS Foundation Trust which took into consideration national best practice and how mental health care could be provided to people in a more community focused way.

**You said we did** - As a result of the views and opinions received the future service will emphasise supporting patients and their carers with transport needs and ensure total clinical staffing levels are maintained across acute and community. Also as a result of feedback, we have prioritised making use of the vacated ward at Bridlington Hospital so that investment already made is not lost as services are relocated and co-located to aid patient care.
b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Service provider engagement has been embedded into the East Riding’s Better Care integration agenda from the outset. Providers from all sectors, including NHS Trusts, were involved in the initial integration workshops which helped provide a steer for the vision and direction of the East Riding’s BCF Plan.

Humber NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust are members of the Better Care Fund Programme Board (responsible for the delivery of the workstreams that underpin the Plan). Along with York Teaching Hospitals NHS Foundation Trust, North Lincolnshire and Goole NHS Foundation Trust and the Yorkshire Ambulance Service NHS Trust these NHS Trusts have also committed to the delivery of the Better Care Fund Plan, demonstrated by their signing up to the local area’s Better Care Fund Concordat which accompanied the April submission of the Better Care Fund Plan.

The current Concordat has been refreshed following the submission of this Plan and along with those already committed to the partnership delivery of the BCF Plan, City Health Care Partnership; a community provider will be encouraged to formally become a partner to the Concordat.

Additionally the Chief Officers within the Humber area, including East Riding of Yorkshire CCG, East Riding of Yorkshire Council, Hull CCG, Hull City Council, Humber Foundation Trust and Hull and East Yorkshire Hospital’s NHS Trust meet on a regular basis ensuring synergy with the aims of the BCF Plans for both East Riding and the Hull Health and Wellbeing Board areas.

The Vale of York CCG has also been a key contributor to the development of the East Riding Better Care Fund Plan and continues to be represented on the Better Care Fund Programme Board given that the Better Care Fund Plan is based on the East Riding of Yorkshire Health and Wellbeing Board footprint that includes Pocklington, a market town which sits within the Vale of York CCG’s boundaries.

As well as extensive engagement in the Better Care Fund programme arrangements, local plans are underpinned by contractual agreements with acute providers and this is being reflected in their organisational operational plans. For example, the activity shifts expected from the acute to community through the delivery of the ambulatory care pathway are reflected in contractual agreements with providers in terms of shift of activity and financial contract values.
ii) primary care providers

There is primary care representation on the Better Care Fund Programme Board; there are currently two GPs who are members of the Board, who represent the East Riding's two largest GP federations, namely Lincolnshire and District Medical Services (LADMS) and Yorkshire Health Partners (YHP).

As referred to in Section 6, above, the Community Care Strategy outlines how an integrated health service is the blueprint for the future delivery across the East Riding of Yorkshire. ERYCCG has worked with General Practice on this Strategy and the implementation of this is key to 'Better Care'.

iii) social care and providers from the voluntary and community sector

Providers from all sectors, including the voluntary sector were involved in the initial integration workshops which helped provide a steer for the vision and direction of the East Riding’s Better Care Fund Plan.

Continued engagement with social care and providers form the voluntary and community sector is the key to co-designing and evaluating models of care that will meet peoples' need.

This can be demonstrated by membership of the Better Care Fund Programme Board, which includes Healthwatch, East Riding Carers’ Advisory Group and East Riding Voluntary and Community Sector Steering Group.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:
- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers’ plans for 2015/16 consistent with the BCF plan set out here?

Delivery of the BCF is dependent upon a shift of funding from the acute sector into alternative home and community based services. In order to make the transition to a lower level of activity in the acute sector possible, investment will be made in community health and social care services. We have not underestimated the impact that this will have on our acute providers and we have focussed our contract discussions and formulated our joint plans accordingly.

As well as extensive engagement in the BCF programme arrangements, our plans are underpinned by contractual agreements with acute providers, for example the activity shifts expected from the acute to community through the delivery of the ambulatory care pathway are reflected in contractual agreements with providers in terms of shift of activity and financial contract values. The contracts for 2014/15 and 2015/16 will be based on the activity and associated financial assumptions set out in Appendix B of the BCF Plan.

The stakeholder organisations involved in the creation of this plan have recognised the challenges that the adoption of an integrated service model will bring but remain
committed to pushing the programme through to completion. A Concordat has been cooperatively developed to establish the principles of joint working that partner organisations will sign up to, evidencing the commitment of these organisations to work effectively and collaboratively for the benefit of the population of the East Riding.

These organisations are also exploring contracting options that will help establish shared risk agreements ensuring that provider and commissioning organisations are provided with some assurance as we develop and implement the required changes. Whole system change on this scale has not been undertaken before in the UK and timescales are ambitious, however, all stakeholders remain committed to delivering the BCF programme in the East Riding.

The focus for this plan is to ensure that individuals are proactively managed and supported to avoid unnecessary admissions to the acute sector and to support timely discharges. The services that we are jointly developing will release efficiency savings in:

- Admissions avoidance;
- Reduced demand on A&E services;
- Reduced length of stay;
- Reduced numbers of delayed discharges.

**Admissions avoidance/reduced demand on A&E**

The developments proposed below, and covered in section 4d, will play a pivotal role in admissions avoidance and reducing demands on A&E, through:

- Better assessment before admission;
- Rapid response, assessment and support services;
- Rapid access to ambulatory clinics, diagnostics, medication and expert advice;
- Improved care coordination and planning;
- Individualised and responsive specialist palliative care and support;
- The expansion of integrated health and social care teams.

**Length of stay/delayed discharge**

For those patients that have been admitted we will ensure that they have clear discharge plans and that the necessary support packages to ensure rapid discharge are in place. This will be delivered through:

- Personalised reablement and/or rehabilitation;
- Improved hospital discharge planning with access to alternative models of care, such as reablement, intermediate care or community hospitals.

These developments will be underpinned by appropriate levels of seven day services and through the use of the single point of access to community health and social care services. Where possible services will be delivered at, or as near to, home as possible.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Scheme name**

Ambulatory Care incorporating:
- Goole, Howdenshire and West Wolds Frailty Support Service (Community Ambulatory Care Pilot)
- Roll out of Ambulatory Care Model
- Acute Ambulatory Care

**What is the strategic objective of this scheme?**

By introducing ambulatory care models across both community and hospital settings we are intending to deliver:
- A reduction in unplanned admissions within the target population.
- An improved patient experience and outcome with reduced morbidity post clinical exacerbation.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The overall model involves a move from the traditional assumption that individuals need admitting to hospital in the event of a clinical exacerbation and that they need to stay there until all their assessments are undertaken. The model promotes:

- Earlier community intervention from a multi-agency team to assess the clinical need to be admitted to a hospital facility with the onus being to keep the individual at home wherever clinically and socially appropriate with packages of health and social care and support being delivered within the individuals own home.

- Where it is not possible to provide care packages in the individual's home, to utilise community based (step up beds) as an alternative to hospital admission or care homes where the social need is more pressing.

- Dedicated patient care pathways within the acute setting for those patients who present at A&E with conditions that are clinically appropriate to be managed within an ambulatory or frailty facility and then discharged home with an appropriate health and
care package and support.

- Availability of rapid access clinics to provide hospital clinical review, advice and care planning as an alternative to A&E attendance, in support of avoiding an admission following A&E attendance and in support of the community care teams managing the individual in their home setting.

- Support in the community to facilitate early discharge and discharge to assess i.e. where a patient is discharged home if clinically safe and other assessments are undertaken within the patient’s own home e.g. physiotherapy.

1) Goole, Howdenshire and West Wolds Frailty Support Service (Community Ambulatory Care Pilot)

The scheme involves the creation of a quick response ‘team’ in the community who will provide rapid access, i.e. within 2 hours, to appropriate health and/or social care assessment and support at times of health or activities of daily living deterioration and within the same timeframe for those individuals in hospital and identified as suitable for ‘discharge to assess’ after the time of discharge.

An outline of the scheme is shown in diagram 1 – page 88.

The service will be available to a cohort of vulnerable patients selected by each of the participating GP practices in the scheme. This cohort of patients will be identical to the 2% of patients identified by practices for purposes of the Unplanned Admissions DES 2014/15.

The central role in the service will be undertaken by a Healthcare Co-ordinator who will carry out a telephone triage in the case of patients in crisis and determine the appropriate intervention required to deal with the problem. This is likely to involve the mobilising of other health and social care providers and co-ordinating their efforts to ensure patients are seen quickly and that appropriate support packages are put in place as required. Members of this virtual ‘team’ will be drawn from a range of different service providers all of whom are committed to the aim of providing the 2 hour response time to deal with patients in crisis.

As the pilot is delivered the model will be developed to ensure that is robust and transferable to other areas across the East Riding. This roll out will commence mid 2015 and continue through to 2016.

2) Acute Ambulatory Care

We are working in conjunction with our main acute sector providers to support them in developing ambulatory care models within the community. At resent the focus is upon Hull and East Yorkshire Hospitals NHS Trust but the principles will be integrated within other contracts. The models being put in place are:

a. Rapid Assessment and Treatment Team (RATT)
An experienced clinical team based at ‘the front door’ of A&E who undertake a comprehensive health and care assessment of admissions into the majors part of A&E to identify the optimal facility in which to undertake initial full assessment and care planning.

b. Ambulatory Care Facility

A facility where individuals who meet admission criteria are transferred from eth front end of A&E straight into a dedicated facility. The facility has an agreed multi-disciplinary team who will assess, diagnose and care plan prior to either admission into the main hospital for a shortened length of stay (minority) or referred back to the community teams to enact the agreed plan of care (majority). The facility will have access to dedicated diagnostic slots to support rapid diagnosis and care planning. A dedicated GP phone line is being provided to support GP decision making.

c. Frailty Pathway

Dedicated pathways for our more frail population members are being developed, supported by a dedicated multi-professional frailty team. When an individual is assessed by the RATT and confirmed as clinically appropriate for the frailty pathway they will be transferred to the management of this team. These individuals will be the more vulnerable members of our population with a number of co-morbidities. The team will undertake diagnosis, condition stabilisation and care planning with the aim of returning the patient to their own home (minority) or admission into the main hospital with a shortened length of stay (majority).

d. Rapid Access Clinics and Medical support lines

Provision of clinics with capacity to accept patients within 24 to 48 hours (depending upon clinical need) to provide consultant assessment, advice and care planning for those individuals who require a degree of acute care clinician review. This is supplemented by the provision of direct access to Consultant advice for GPs to support them in both delivering care within the community and assessing whether an individual would benefit from hospital assessment / admission.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

1) Goole, Howdenshire and West Wolds Frailty Support Service (Community Ambulatory Care Pilot)

The service is being commissioned by the GP commissioners in the Goole, Howdenshire and West Wolds locality on a 12 month pilot basis. The locality is one of 5 geographically based commissioning groups that comprise East Riding of Yorkshire Clinical
Commissioning Group.

The main service providers will comprise:

- Humber Foundation Trust (HFT) – responsible for providing patients with access to a single point of telephone access, the healthcare co-ordinator function as well as enhanced community health team input

- GP practices in the Goole, Howdenshire and West Wolds locality (conflict of interest issues are being managed through a project steering group and the separation of the commissioning and provision roles) – responsible for identifying and managing the patient cohort and monitoring the effectiveness of interventions.

- East Riding of Yorkshire Council - responsible for providing dedicated Case Assessment Officers and facilitating access to social care packages

The CCG is also considering the inclusion of other providers in the delivery of the service model, notably independent providers of social care packages and organisations within the voluntary sector.

As the model rolls out different providers may become involved in the delivery chain dependent upon the geographical locality. This will be reflected as the work progresses.

2) Acute Ambulatory Care

- At present the focus is upon Hull and East Yorkshire Hospitals NHS Trust. They will provide the hospital based services but wrapped around this is the community and social care provided by ERY Primary Care, Humber FT and ERY Local Authority Care Teams.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital (Avoiding unplanned admissions enhanced service: proactive case finding and care review for vulnerable people’ NHS England Gateway ref 01520 (April 2014)).

Data suggests that many patients only attend A&E or are admitted to hospital as an emergency because of a lack of support in the community and that this is particularly true for those vulnerable patients who have frailty.

Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body’s physical and psychological reserves. The
condition varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse (‘Fit for Frailty: Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings’ - Published by the British Geriatrics Society.)

Locally, across the East Riding, the age structure shows a relatively large number of older people, and population predictions suggest an overall population increase over the coming five years from 348,000 in 2012 to 364,300 by 2017 (ONS 2008 -based projections - May 2010), particularly among older people for the East Riding. Projections suggest that by 2017, in the East Riding, 77,000 people will be over 65 years old and 20,000 over 80. This will give rise to an increase in the number of people who will need to access community care for care and support to enable them to remain in their place of residence and avoid unnecessary hospital admissions.

Within these groups there is a significant sub set of individuals who have clinical conditions that can provide challenges in ensuring that they are able to understand and retain what can be complex information regarding the on-going management of their clinical conditions. For example it is predicated that the numbers of over 65s who are living with a moderate or severe learning disability will increase from an estimated 215 in 2014 to an estimated 256 by 2020.

It is recognised nationally that patients with a long term condition (LTC) account for more than 50% of all GP appointments; 65% of all out patient appointments; over 70% of all inpatient bed days (2009 General Lifestyle Survey). This demand arises from the high level of individuals living with a LTC; in people of 65 years of age and over the number of multiple LTCs increases. A number of these long term conditions, especially when in combinations with other long term conditions and the impacts of the aging process, generate varying levels of frailty.
**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

1) The Goole Howdenshire and West Wolds Frailty Support Service (Community Ambulatory Care Pilot).
   The cost of setting up the Rapid Response pilot which will run for 12 months from November 2014 to October 2015 will amount to just under £400,000. This comprises £325,000 of expected recurrent costs together with £74,000 required for pump priming and one off expenditure. An outline of the expected expenditure is set out below:

<table>
<thead>
<tr>
<th>Area of expenditure</th>
<th>Expected recurrent costs (£’000s)</th>
<th>Pump priming funding (£’000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Co-ordinator</td>
<td>51.3</td>
<td></td>
</tr>
<tr>
<td>Single Point of Contact</td>
<td>30.3</td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td>109.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Social Care Officers</td>
<td>94.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Care home beds and homecare packages</td>
<td>20.3</td>
<td>28.7</td>
</tr>
<tr>
<td>IT support</td>
<td>20.0</td>
<td></td>
</tr>
<tr>
<td>GP Practice monitoring</td>
<td>18.8</td>
<td>7.5</td>
</tr>
<tr>
<td>Other costs</td>
<td></td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>324.8</strong></td>
<td><strong>73.7</strong></td>
</tr>
</tbody>
</table>

This is a pilot to evaluate the full potential for roll out to the remaining Localities. Full budget is £1.6m. To include HEYHT Frailty model and Local Authority support projects.

Funding has been identified to support the roll out of the model and is currently circa £143,814

2) Acute Ambulatory Care

As part of the system resilience planning the ERY CCG has invested £900,000 in Hull and East Yorkshire Hospitals NHS Trust to support them in developing the estate and
workforce changes required to deliver the acute ambulatory care model. The actual activity will be paid at a local tariff which will be agreed as part of the 15/16 contracting round once activity data is available to establish a baseline.

### Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The total Ambulatory care model has a potential (based on the Kings Fund estimates) of a maximum of 18% of the Avoidable Admissions, which for 2013/14 were 6,275. Total potential is therefore, 1,129 spells. This will be delivered initially in part by the Goole Howden and West Wolds Hub and the Acute Ambulatory Care project 2015/2016. The remaining potential will be delivered by the other CCG Localities when the GH&WW model is rolled out to them. Some of this potential is already being planned within the LTC comorbidity clinics, as this will treat the same cohort of patients.

The detail of the admissions reduction is included within the BCF Project summary.xlsx document.

Goole Howden & West Wolds Hub will deliver a reduction of 106 spells.

The Acute Frailty model will initially deliver a reduction of 730 spells.

It is anticipated that the roll out of the community ambulatory care model will save an additional 294 spells, although the hubs will also ultimately prevent the 730 spells being managed by the Acute Frailty model from reaching secondary care services.

### Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Activity information will be recorded and monitoring reports will be available on a monthly basis for the consideration of the Steering Group. The rate of unplanned admissions involving the 2% cohort will be monitored based on data to be supplied by the GP practices which will be benchmarked against those GP practices who are not in the locality but who are participating in the Unplanned admissions DES and have their own 2% cohorts.

Each GP practice in the locality will also undertake monthly MDT meetings examining all unplanned admissions involving vulnerable patients in the 2% cohort in order to assess whether the admission could have been prevented and what support would have made a difference to the patient.

### What are the key success factors for implementation of this scheme?

Full engagement by the key service providers, with regular attendance and participation the steering groups.

Identifying the necessary staffing capacity to create the Healthcare Co-ordinator role and to resource the other key functions (District nurses, therapists, OOH GPs, social care assessment officers).
Ensuring there is adequate funding to meet implementation and running costs. Ensuring consent of patients is in place to allow sharing of records across health and social care professionals.
Frailty Support Service Model – Diagram 1

Patient flagged on 2% Cohort on SPOC IT System

Patient Referral:
- Patient
- Carer/Care Home
- Other (GP practice, hospital, NCS, Social care, etc)

08:00 – 22:00 Rings Single Point of Contact (NCS option) line

Healthcare Co-ordinator rings referrer/patient to triage and decide on next steps

Patient flagged on 2% Cohort on SPOC IT System

Healthcare Co-ordinator provides telephone advice/undertakes home visit/intervention

No further action required

Healthcare Co-ordinator provides telephone advice/undertakes home visit/intervention

Ambulatory care service (new service due to be available during 2014/15)

NCS Advice/Visit (inc Therapies/ MH etc.)

999

Step up/Step down beds

GP Advice/Visit

Social Care Advice/Visit

Marie Curie

Mobile GP

OOH GP/FCP

Homecare Packages

Step up/Step down beds

GP Advice/Visit

Social Care Advice/Visit

Marie Curie

Mobile GP

OOH GP/FCP

Healthcare Co-ordinator provides telephone advice/undertakes home visit/intervention

No further action required

Ambulatory care service (new service due to be available during 2014/15)
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>Cardiac Rehabilitation</td>
</tr>
<tr>
<td>What is the strategic objective of this scheme?</td>
<td>Improve outcomes for patients with agreed levels of cardiac disease by promoting: 1) Lifestyle change to increase gentle exercise, good eating habits and minimisation of ‘bad’ habits 2) Increased levels of self-care and condition awareness. This will be done by expanding on the existing Cardiac Rehabilitation Service. This will contribute to a stabilisation of cardiac health, a reduction in unplanned admissions and improvements in an individual’s quality of life.</td>
</tr>
</tbody>
</table>

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The service will target service users and individuals who would benefit from a cardiac rehabilitation programme.

<table>
<thead>
<tr>
<th>In-scope patients</th>
<th>2013/14</th>
<th>Optimal referral and uptake rate</th>
<th>Expected annual activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people discharged alive – acute myocardial infarction</td>
<td>373</td>
<td>68%</td>
<td>254</td>
</tr>
<tr>
<td>Number of people discharged alive – coronary artery bypass graft (CABG)</td>
<td>84</td>
<td>85%</td>
<td>72</td>
</tr>
<tr>
<td>Number of people discharged alive – percutaneous coronary intervention</td>
<td>277</td>
<td>85%</td>
<td>236</td>
</tr>
<tr>
<td>Number of people discharged alive – chronic heart failure</td>
<td>253</td>
<td>53%</td>
<td>134</td>
</tr>
<tr>
<td>Number of people discharged alive – implant of a cardiac defibrillator (ICD)</td>
<td>23</td>
<td>85%</td>
<td>19</td>
</tr>
<tr>
<td>Number of people diagnosed with unstable angina (included at national assumption rates to avoid double counting)</td>
<td>93</td>
<td>100%</td>
<td>93</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Total</td>
<td>1103</td>
<td>807</td>
<td></td>
</tr>
<tr>
<td>% expected activity on cohort</td>
<td>73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population at level 2 per risk stratification</td>
<td>1954</td>
<td>1195</td>
<td></td>
</tr>
<tr>
<td>Additional expected by direct GP referral (assume lower take up)</td>
<td>851</td>
<td>10%</td>
<td>85</td>
</tr>
<tr>
<td>Total activity required</td>
<td></td>
<td></td>
<td>892</td>
</tr>
</tbody>
</table>

The service model would include the provision of tailored packages of cardiac rehabilitation care in a community based setting including active self-management and use of digital health technologies across phase 3 and phase 4 of the nationally agreed cardiac rehabilitation programme.

The investment would allow locality based programmes to be developed in the rural communities of the East Riding to ensure a high uptake is achieved.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Service will be commissioned within the Prevention and Self-Care work stream of the BCF and via the appropriate procurement channel.

The design of the service will include:

- Users and carers of the current service – to ensure that the service is co-designed to meet the needs of the users of the service
- The current provider and secondary care – To ensure that lessons are learned from the experience of the current service, and to provide clinical expertise to design the appropriate model of care
- GP Commissioners– to ensure the service is commissioned with clinically led focus
- ERYC Public Health Team– to ensure that the model meets the needs of the population of the East Riding.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

NICE Commissioning Guide 40 (2011)\(^2\) states:

\(^2\) [http://publications.nice.org.uk/cardiac-rehabilitation-services-cmg40](http://publications.nice.org.uk/cardiac-rehabilitation-services-cmg40)
“There is evidence that exercise-based cardiac rehabilitation:

- is effective in reducing total and cardiovascular mortality and hospital admissions in people with coronary heart disease;
- reduces all-cause and cardiovascular mortality rates in patients after MI when compared with usual care provided when it includes an exercise component;
- significantly reduces hospitalisation for chronic heart failure and;
- significantly improves quality of life and exercises tolerance for people with heart failure.”

NICE Commissioning Guide 40 proposes that cardiac rehabilitation should be integrated within secondary prevention services and be offered as a comprehensive package, including exercise, education and psychological support, placing emphasis on helping patients become active self-managers of their conditions.

The National service framework for coronary heart disease ³ recommended that every hospital should ensure that more than 85% of people discharged with a primary diagnosis of acute MI or after coronary revascularisation should be offered cardiac rehabilitation. Cardiac rehabilitation is also recommended in NICE clinical guideline 94 for unstable angina and non-ST-segment elevation ⁴

NICE clinical guideline 108 on chronic heart failure (2010) makes a new recommendation supporting cardiac rehabilitation for people with chronic heart failure.⁵

The BACPR (British Association for Cardiovascular Prevention and Rehabilitation) Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation (2012, 2nd Edition) ⁶ cites “overwhelming evidence that comprehensive cardiac rehabilitation is associated with a reduction in both cardiac mortality (26% – 36%) and total mortality (13% – 26%). It is further stated that “there is emerging evidence that cardiac rehabilitation is also associated with a reduction in morbidity, namely recurrent myocardial infarction and a 28% - 56% reduction in costly unplanned readmissions”. Cardiac rehabilitation supports improvement in functional capacity, quality of life and early return to work, as well as the development of self-management skills, making it “one of the most clinically and cost-effective therapeutic interventions in cardiovascular disease management”.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan (see table below)

Using the British Association for Cardiac Rehabilitation recommendations, the cost per patient to provide phase 3 and phase 4 cardiac rehabilitation is £615. For the cohort of patients likely to accept a place on this programme (1147 for 2013/14, but growing at 3% per year) requires annual investment of £640k. It is therefore suggested that a phased rollout is commissioned to ensure that the model and

⁴ http://guidance.nice.org.uk/CG94
⁵ http://www.nice.org.uk/CG108
⁶ http://www.bacpr.com/resources/15E_BACPR_Standards_FINAL.pdf

Page 92 of 164
Part 1 V13 271114
cumulative activity assumptions are correct as follows:

<table>
<thead>
<tr>
<th></th>
<th>Number of patients seen (at £615 per patient)</th>
<th>Recurrent Cost</th>
<th>Setup cost (non-recurrent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>335</td>
<td>£205,864</td>
<td>50</td>
</tr>
<tr>
<td>2016/17</td>
<td>650</td>
<td>£399,735</td>
<td>25</td>
</tr>
<tr>
<td>2017/18</td>
<td>1004</td>
<td>£617,591</td>
<td>25</td>
</tr>
</tbody>
</table>

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This will allow testing of the return on investment. If a 28% - 56% reduction in costly unplanned admissions and readmissions can be achieved, as suggested by BACPR (British Association for Cardiovascular Prevention and Rehabilitation) *Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation* (2012, 2nd Edition).

If we assume a reduction in line with the average of these results (30%) this would lead to cumulative reductions of:

<table>
<thead>
<tr>
<th></th>
<th>Number of Emergency admissions reduced</th>
<th>Recurrent Cost impact @ £920</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>89</td>
<td>£820.85</td>
</tr>
<tr>
<td>2016/17</td>
<td>173</td>
<td>£159.389</td>
</tr>
<tr>
<td>2017/18</td>
<td>268</td>
<td>£246.255</td>
</tr>
</tbody>
</table>

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance monitoring and evaluation with service users and providers and via NEL admissions.

**What are the key success factors for implementation of this scheme?**

1. Co-design of the service with users, clinicians and public health to ensure the service meets the needs of the population and users.
2. Ensuring the infrastructure is in place to allow the rollout of classes across the East Riding
3. Ensuring the model designed is feasible in terms for recruiting to the workforce required
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>Collaborative Falls Pathway.</td>
</tr>
<tr>
<td>What is the strategic objective of this scheme?</td>
<td>Reduce the number and impact of falls in the East Riding population aged 65 and over.</td>
</tr>
</tbody>
</table>

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

To work in collaboration with East Riding of Yorkshire Council (ERYC), other statutory, community and voluntary agencies to reduce the number and impact of falls in the older population of East Riding of Yorkshire CCG:

- To provide effective treatment and rehabilitation for those who have fallen.
- To provide leadership and co-ordination of collaborative falls pathway so it can support the older population to maintain their independence and improve the quality of life of those who fall or are at risk of falling.

The key objectives for this service are defined as:

- To provide the co-ordination and leadership across all health and social care providers to ensure seamless pathways of care, good communication, data collation and information sharing between all services.
- To develop multi-agency collaboration to deliver falls prevention education and training, promote active lifestyles associated with falls prevention to the general public, those who care for older people and health and social care professionals.
- To support the continued development of evidence based exercise classes for older people in a variety of settings to prevent falls and promote improved strength and balance.
- To support generic health, social care and other service providers to undertake the falls screening level one assessment and offer appropriate advice, intervention and referral.
- To undertake specialist assessments and deliver management plans for those people who have fallen. To investigate the cause and reduce the likelihood of subsequent falls, working closely with patients, carers, health and social care
professionals and other organisations as appropriate (see interdependencies).

- To be a specialist resource in falls prevention and active management of fallers for the health and social care professionals working with East Riding of Yorkshire CCG patients.
- To work with care homes to reduce the incidence of falls.

The service model reflects the collaborative and multi-agency nature of the falls pathway which will allow the individual to travel around and through the service. One of the strengths of many of the health promotion interventions is their creation of a cycle of change that relies upon an individual recognising their own needs.

**Universal Level – Health Promotion and Prevention, Open Access Exercise Groups**

Public health data analysis and promotion campaigns to raise public awareness of falls and how to prevent them, promote good bone health and healthy lifestyles to reduce falls risk.

Exercise groups to maintain and improve general fitness, balance and confidence run by a range of service providers including:

- Sports, Play and Arts Services.
- Health Trainers.
- Volunteer exercise mentors.

Falls awareness and prevention training and education for NHS, Social Care, Community and Voluntary Sector staff and volunteers.

**Level 1 – Basic Assessment and Prevention**

Level 1 is the contact/overview assessment and will be the initial point of contact for all new referrals for needs. At this stage, those completing the falls screening will attempt to remedy certain risk factors themselves. This may be moving loose rugs or recommending the purchase of appropriate footwear for the person. If these do not reduce the risk then it will be essential to offer the person a higher, more in depth level of assessment.

The basic assessment and falls prevention can be carried out by any Tier 1 professional (e.g. social care, home safety services, fire safety officer, community and voluntary sector Red Cross, etc.). It is expected that on completion of a Level 1 assessment form, that in addition to interventions offered and onward referral, a copy of the form will be submitted, and a log made on the Falls Register held by the falls co-ordinator within the community falls services provider.

Community hospitals should also complete a falls checklist for all inpatients as outlined in the Community Hospitals Service Specification.

**Level 2 - Specialist Assessment**

Level 2 is the element of the falls service that will facilitate a more specific and specialist assessment and interventions such as Occupational Therapy, Physiotherapy or Nursing. This assessment can be carried out by any generic health care professional (following training) and should be logged as an activity carried out by the specific service. It provides a more in depth assessment of medical conditions and medication management in addition to a more detailed risk assessment and review for equipment needs.

Community hospitals should offer / undertake level 2 assessments in line with the
latest best practice guidelines.

Assessments and interventions which would meet the level 2 criteria are also completed by the ERYC Disability Resource Service for their client group. A significant number of patients may then require interventions such as programmes to develop muscle strength, balance training and/or assistive technology. In addition to the intervention offered, a referral should be made to Level 3 as appropriate.

Level 3 - Specialist Falls Service Assessments

A specialist assessment includes a series of cardiovascular, respiratory and vascular examinations plus neurological assessment, balance and gait assessment, medication review, ECG and interpretation, visual acuity, and social situation.

Contributing factors of the fall are established and a management plan developed with the patient (and their carer as appropriate). Treatment options would be discussed with the patient and their carer, referral to other services undertaken for further treatment as required.

Level 3 assessments should be community facing where ever possible.

The falls pathway requires very close working between the specialist Collaborative Falls Services and community services e.g. Neighbourhood Care Teams (NCT). This will be achieved by clearly defined pathways which may include the use of a community hospital bed providing a safe environment for those people who are at risk of falling. This will facilitate an improved service on the ward in relation to falls prevention and management by working in partnership with Lifeline. This will not only improve patient safety whilst being an in-patient in the hospital, but facilitate an enhanced experience relating to discharge planning, as patients are able to familiarise themselves with Lifeline equipment whilst being in a managed environment. Ultimately this will enable patients to be assessed and supported at home or in an independent sector bed and help to reduce anxiety regarding potential new equipment.

Management Plan following Level 3 - Specialist Falls Service Assessment

The management plan will be fully discussed with the patient (and carer) and they will be given the appropriate verbal and written advice for their individual treatment plan. A copy of the plan will be made available to the patient on their request. The patients GP will also receive a copy of the treatment plan and patients may be added to their practice osteoporosis register and be prescribed bone sparing treatment in line with the 2012/13 Quality and Outcomes Framework (QOF).

If required by the management plan the service will provide on-going balance, gait and muscle strength programme for people who are at high risk of falls.

If the client has memory problems their carer will be offered falls prevention, support and mobility advice to improve their confidence in moving handling and falls prevention techniques for individuals with poor balance and gait.

Falls Diversionary Pathway (Yorkshire Ambulance Service)

The falls diversionary pathway is a partnership between Humber NHS FT, the
Yorkshire Ambulance Service (YAS) and East Riding of Yorkshire Council. The pathway is designed to stop inappropriate attendances at Accident and Emergency (A&E) departments for people who have experienced a fall but do not require immediate medical intervention. The pathway is designed so that individuals who have fallen are followed up in the community by the Neighbourhood Care Team (NCT).

When an ambulance crew is called to attend a person who has fallen they will assess the individual. If the person does not require immediate medical attention and can be left at home they will forward patient details to the NCT via a single point.

Referrals received by the NCT before 14.00, will be assessed that day. Referrals received after 14.00, will be assessed before 12.00 the following day. Referrals to the NCT are accepted 7 days per week (including bank holidays). The single point will take referrals 24 hours per day, seven days per week. All referrals are voice recorded. The NCT is informed by phone of the referral and followed up by a fax with patient details and reason for the referral.

Criteria for referral:

- Registered with an East Riding GP.
- Patient has consented to the referral being made.
- Is an adult (aged 18 years and over).
- The person has fallen and is at risk of future falls and potential injury.
- They would benefit from a follow up level two falls risk assessment in the community.

In-reach (working with Care Homes)

In conjunction with commissioners a targeted approach will be undertaken to identify care homes with a medium-high level of fallers. Information will also be collated from Yorkshire Ambulance Service (YAS) ‘Frequent Flyer’ reports. The Falls Service will support care homes to reduce the number of fallers by:

- undertaking an environmental review.
- the specialist assessment of individual residents who have fallen.
- provision of linked named nurse and therapists (e.g. physiotherapist and occupational therapy) working in the named care homes to monitor the number of falls, deliver improvements in falls prevention to whole of care home and to individual identified patients who have fallen.
- regular teaching sessions within all care homes for all care staff - the teaching would be a rolling programme to support staff turnover.
- collation of data from fallers within named care homes onto the falls register held by the falls coordinator.

Co-ordination and Leadership of the Collaborative Falls Pathway

This element of service will cover:

- Development and coordination of the collaborative approach between the agencies working within the falls pathway to improve inter agency
communication, opportunities for collaborative working and training.

- Development of infrastructure to enable seamless transfers of care from acute to community services including strong links to secondary provider Accident and Emergency Services, minor injury units, inpatient wards, fracture and bone health clinic and other outpatient services.
- Mapping of existing exercise classes and other relevant community services and updating of information for patients, their carers and local communities.
- Establishing and maintaining the Falls Register.
- Collation and analysis of falls assessments, YAS data (999 and 111), data from A&E departments and minor injury units plus other information to identify falls hotspots, patients requiring additional support and areas where services could be improved.
- Contribute to promotional material on healthy ageing and exercise to reduce falls.
- Co-ordinate the dissemination of home activity and exercise class information to the target 65+ population within the East Riding of Yorkshire CCG.
- Develop links with primary care to support practice osteoporosis registers, provide training and information and encourage primary care staff to offer level one falls assessments and prevention.
- Provision of on-going training to health, social care, community and voluntary sector staff in a range of settings that will be appropriate to their needs.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Falls Service cannot work in isolation and must work with partners to address the needs of people within East Riding of Yorkshire who have, or who are at risk of falling. Strong partnership working is expected with other statutory agencies, particularly Adult Social Care, and non-statutory sector providers, to deliver seamless services. Effective relationships are expected to be established and maintained.

Partners will include, but are not limited to:
Wider community, responsible for identifying patients at risk of Falls
- Social Care Private Providers.
- Fire Service.
- Voluntary Sector.

Low level advice and identification of patients at risk of falls
- GPs and Primary Care Teams.
- Other Health Service Providers.
• Yorkshire Ambulance Service.

Diagnosis and rehabilitation:
• East Riding of Yorkshire Council.
• Community Equipment Service Provider.
• Humber FT

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Falls and fragility fractures are a significant public health challenge, with incidence increasing at approximately 2% per annum. National data has shown the rate of falls increases with age and in any one year, one in three people over the age of 65 and one in two of those over 80 will fall. The severity of the impact of falls also increases with age, hip fractures are the most frequent fractures caused by falls and also the commonest cause of accident related death.

As well as the physical impact there are psychological consequences:

Fear of falling, loss of confidence, the loss of mobility and subsequent independence. Over half the people who fracture their hip are not able to return to their usual place of residence.

Services for older people were transformed by the launch of the National Service Framework for Older People in 2001.

The National Institute for Health and Clinical Excellence (NICE) guidance in 2005 supported the drive for continuous clinical improvement. ‘The Assessment and Prevention of Falls in Older People’ 2009 provided commissioners of NHS and Adult Social Care Services with best practice guidance and a systematic approach to fall and fractures prevention.

It stated that the following community interventions to restore confidence and reduce future injuries had the best evidence base:

- a falls care pathway.
- a falls service.
- a falls co-ordinator.
- multi-factorial interventions.
- community-based therapeutic exercise.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB
Expenditure Plan

Total expenditure over 2 years £340,000.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Based on NICE Guidance\(^1\), there is significant evidence that a multi-disciplinary approach to rehabilitation, combined with a strength training approach, reduces the incidence of falls in the at risk populations. Evidence shows that this model can reduce falls up to 17\(^2\). As this is year 2 of the local programme a further reduction of 10% of NEL is projected.

This initiative will reduce Non Elective admissions as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>NEL Falls Baseline inc 3% growth</th>
<th>Reduction</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/14</td>
<td>1338</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Projected 14/15</td>
<td>1378</td>
<td>138</td>
<td>1240</td>
</tr>
<tr>
<td>Projected 15/16</td>
<td>1240</td>
<td>124</td>
<td>1116</td>
</tr>
</tbody>
</table>

This initiative will reduce Non Elective admissions as follows:

2014/15 138 spells (already in original plan)
2015/16 124 spells

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes of the service are:-

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill-health or following injury.
- Ensuring people have a positive experience of care.
- Treating and caring for people in safe environments and protecting them from avoidable harm.

There are a number of key service performance indicators agreed within the
contractual arrangements between East Riding of Yorkshire CCG and the service provider Humber Foundation Trust.

A Falls Steering Group has been set up to enable continued review of the services and KPIs to monitor if any changes are required to improve patient outcomes.

**What are the key success factors for implementation of this scheme?**

- Continuation of the Falls steering group, with engagement and commitment of wider partners in the falls pathway developments.
- Ensuring patient information can be shared robustly to allow referral into the service
- Ensuring there is adequately trained staff and community to identify patients at risk of falls
- Ensuring there is adequate workforce to provide the falls service
ANNEX 1 – Detailed Scheme Description

Scheme ref no.

4

Scheme name

Long Term Conditions Clinics

What is the strategic objective of this scheme?

To support people with multiple long term conditions to enable them to achieve and maintain the best possible quality of life.

The strategic aims for this scheme are

1) an increase in the ability of individual’s ability and confidence to self-manage their condition;
2) a reduction in both planned and unplanned admissions associated with the improved control / active management of the clinical condition.

The Long Term Conditions (LTC) Clinics are delivered through Primary Care to support people with multiple long term conditions to enable them to achieve and maintain the best possible quality of life with their conditions. Medication reviews to be undertaken to provide appropriate cost effective prescribing. It is anticipated that there will be a reduction in non-elective spells and a reduction of A&E attendances. Patients’ ability to manage their long term conditions will increase with an increase in patient satisfaction.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The LTC clinics will provide a standardised approach to the development and delivery of clinics for people with multiple LTCs and increase confidence and competence of patients to self-manage and share the care of their condition.

The clinics are based in Primary Care and form part of an agreed consistent pathway of care for people with LTCs across the East Riding, which will ensure care is effectively co-ordinated.

The approach is multi-disciplinary and multi-agency, ensuring appropriate input from and signposting to health and social care to meet the specific needs of the individual patients.
Patients will be more involved in decisions about their care (shared decision making) and will have a better understanding of their condition(s).

Support will be tailored to meet individuals’ needs and will increase patients understanding of their conditions, their self-confidence and self-management.

Patients will have a Personalised Care Plan, with personal goals which they have developed and agreed.

The Long Term Conditions Clinics will meet the needs of a large number of patients, and will maximise use of existing services.

The clinics will avoid duplication of work for staff and the patients.

The agreed list of Long Term Conditions are:

- Hypertension.
- Diabetes.
- Ischaemic heart disease.
- Stroke/TIA.
- Heart failure.
- COPD.
- Dementia.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The East Riding of Yorkshire CCG commissions the services through 27 of the 37 GP practices across the East Riding of Yorkshire area. The practices are responsible for providing this service. Practices are expected to link in:

- Local community and voluntary groups when practices identify patients with social or needs around loneliness.
- Social care if assessment for social support is required
- Specialist services, such as smoking cessation, if indicated and agreed with the patient as part of their personal care plan.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

It is recognised nationally that patients with a long term condition account for more than 50% of all GP appointments; 65% of all out patient appointments; over 70% of all in patient bed days.

This demand arises from the high level of individuals living with a LTC; in people of 65 years of age and over the number the multiple LTCs increases.
It is anticipated that by 2025 there will be:

- 18 million people in England with a LTC.
- 3.3 million people aged 65 and over with some disability with:
  - 2.4 million receiving informal care at home.
  - 280,000 people in residential care.
  - 170,000 people in nursing homes.
- A forecast rise in total long term care expenditure to £26.4 billion. This is equivalent to a rise from 1.4% to 1.8% of GDP.

In Hull and East Riding 17% of the population are aged 65 and over (ONS Data 2009), based on known prevalence figures this means there are around 54,000 individuals living with one or more LTCs. In addition there are a high number of individuals under the age of 65 who are living with one or more LTCs.

There is a growing evidence base and many examples of good practice from the country which support the redesign of LTC care along the lines of the Hull and East Riding LTC Model. The LTC model has been designed to reflect local needs, as integrated care; and self-management. Long Term Condition clinics are one element of the model, and an over view of the evidence base is included. There is growing evidence of the use of predictive modelling which demonstrates that they are more accurate than clinical opinion (Curry et al 2005; Allaudeen at al 2011; Lewis et al 2011).

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£478,000 over 2 years based on £34.20 per patient with a LTC comorbidity paid to the practice. Twenty Seven practices signed up with a total relevant population of £13,976. Detailed financial investment breakdowns included in The Key Success Factors section below.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This initiative will reduce Non Elective admissions as follows:

2014/15 113 spells (Already in original plan)
2015/16 80 spells

NB. The LTC patients are also part of the cohort of patients seen within the Ambulatory care project (Annex 1 Scheme 1). Therefore only the partial effect of the patients outside of the Hull and East Yorkshire hospital catchment is built into the total spell reduction i.e 29 in 2015/2016.
**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

GP practices providing this service are required to complete a monthly data submission that sets out the following:

- How many reviews have been undertaken?
- What LTCs the assessed patients have.
- If a Personal Care Plan was issued.
- An audit of prescribing changes.

The CCG reviews on a monthly basis the number of non-elective admissions for diagnoses codes associated with the scheme to assess what the impact is.

This information is reviewed as part of the monthly QIPP meetings.

Providers of the service are contracted to provide patient surveys 6 monthly to understand patients’ experience of the clinics.

**What are the key success factors for implementation of this scheme?**

The LTC clinics are still in their infancy however initial feedback is promising, in year one the scheme is expected to reduce the cost of prescribing and audits collected to date are all achieving this objective.

The CCG has 85% of the population covered by clinics with further practices expressing an interest to provide clinics resulting in a further tender process being rolled out over the coming months.

Key success factors include:

Signup of GP practices to ensure the clinics take place
Ensuring there is the require workforce available to practices to allow a full medication review to take place

Key success factors include:

Signup of GP practices to ensure the clinics take place
Ensuring there is the require workforce available to practices to allow a full medication review to take place
### LTC Planned Reviews

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,491</td>
<td>7,574</td>
</tr>
</tbody>
</table>

### NEL Admissions Plan

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,727 (Actual)</td>
<td>1,555</td>
</tr>
</tbody>
</table>

### Prescribing Savings Plan

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£135,000</td>
</tr>
</tbody>
</table>

South Holderness practice experience within the LTC clinics demonstrated an average of 10% reduction in NEL admissions over 2 years ranging from 3% in the first year and 22% in the second.

The agreed Diagnosis that apply to this scheme are:-

#### Diagnosis Group

<table>
<thead>
<tr>
<th>Diagnosis Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC - Asthma</td>
</tr>
<tr>
<td>LTC - CHD</td>
</tr>
<tr>
<td>LTC - Diabetes</td>
</tr>
<tr>
<td>LTC - Epilepsy</td>
</tr>
<tr>
<td>LTC - Stroke</td>
</tr>
</tbody>
</table>
## ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheme name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary Rehabilitation</td>
</tr>
</tbody>
</table>

### What is the strategic objective of this scheme?

The overall strategic objective of the scheme is to expand on the existing Pulmonary Rehabilitation Service by incorporating other closely allied services that work with the same group of patients to improve outcomes for patients with agreed levels of cardiac disease by promoting:

1) Integrated service delivery;
2) Lifestyle change to increase gentle exercise, good eating habits and minimisation of ‘bad’ habits;
3) Increased levels of self-care and condition awareness.

This will contribute to a stabilisation of cardiac health, a reduction in unplanned admissions and improvements in an individual’s quality of life.

### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The aim of the service is to provide a multidisciplinary integrated community based service to improve the care of people with COPD the service will comprise of:

- Spirometry and Assessment service;
- Pulmonary Rehabilitation service;
- Community oxygen assessment service and on-going support for people on long term oxygen;
- Community nebuliser service.

These services will be supported by effective links to the existing community and specialist respiratory services including other practitioners such as General Practitioners, Practice Nurses and Respiratory Physicians, Community / Practice Pharmacists and specialist palliative care services for people with COPD requiring care at the end of their lives.
The community respiratory service in the East Riding of Yorkshire will be delivered by an integrated Community Respiratory Team, which includes respiratory specialists, pulmonary rehabilitation, home oxygen assessment and review services (HOS-AR) and nebulisers. This will ensure that the patient's experience of the care they receive is positive, as is their carers, and that pathways avoid duplication and ensure a joined up, streamlined delivery.

The overarching aims of the community respiratory services include the delivery of:

- accessible care provided closer to home;
- holistic individualised assessment, including the identification of carers and onward referral for those who would benefit from carers assessment or signposting to other services;
- advice/health education to patients and unpaid carers;
- on-going assessments to help monitor and manage the condition(s);
- individualised care planning, with the use of personalised care plans, ensuring that any communication special needs are taken in account, enabling patients and their carers to identify their priorities and agree their goals;
- use of best practice in relation to the care delivered and medication prescribed;
- services which ensure that the principles of the Mental Capacity Act always apply and that where an individual is identified as lacking the capacity to make a specific decision, any decisions are made appropriately in their best interests;
- patient outcomes that show improvement in patient quality of life following the involvement of the services, and high levels of patient satisfaction;
- support and information for patients enabling them to better understand and manage their condition(s) themselves and where a patient has a learning or intellectual disability, to make reasonable adjustments to enable the patient or carer;
- involvement, support and high level of satisfaction from carers;
- prevention of unnecessary admissions to hospital of patients in crisis, which could be safely looked after at home with support;
- timely discharge of patients from hospital who no longer require acute medical intervention;
- support for individuals with palliative and/or end of life care needs;
- requests for assessment for equipment where there is an urgent need within 24hrs, e.g. palliative care;
- skilled, competent, multi-disciplinary workforce delivering evidence based care;
- integrated working both within the Humber NHS Foundation Trust and with external organisations such as the local authority, secondary care providers, general practitioners and the voluntary sector to ensure that patients receive care which is joined up and avoids duplication.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

ERYCCG is commissioning this from Humber FT as an addition to the block contract that already exists with this provider.

Humber FT – provision of the service within the agrees specification, and support the wider community to develop self-managed exercise programmes. GPs and secondary care – refer appropriate patients into the service, based on clinical need care.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

COPD causes around 23,000 deaths in England each year, with one person dying from the condition every 20 minutes. 2012/13 QOF disease registers indicate that there are in the region of 6,300 people registered with East Riding GPs known to have COPD. The prevalence is particularly high in the Bridlington, Goole and South Holderness areas within East Riding.

There is strong evidence as to the effectiveness of this service, which is recommended by NICE:

“Pulmonary rehabilitation should be made available to all appropriate people with COPD including those who have had a recent hospitalisation for an acute exacerbation”.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£100,000 in 2014/15, £200,000 additional in 2015/16.

The additional funding will support the recruitment of a Physiotherapist at Band 8a and Band 6 support staff. There are also additional costs to support additional venues to run the service from.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below
There is already a service provided by Humber that has started 157 patients on the programme in the last year and has achieved a reduction in NEL of 17% following investment of £100K. There are significant capacity issues in this service due to demand in the area and the limited investment provided, with a waiting list of 400 patients and a significant proportion of these waiting over 52 weeks; this proposal is therefore to increase this funding by an additional £200K to allow the 3 areas with the high levels of prevalence to have fixed pulmonary rehabilitation sites. This will allow further patients to be seen and is likely to achieve further NEL savings as demonstrated with the current service.

Other studies have shown an 11% reduction in NEL following the introduction of the programme, and Cochrane Collaboration reviewed 5 studies and showed a significant reduction in re-admission following pulmonary rehabilitation, but this varied in studies between 0-30%.

2013/14 COPD NEL activity is 649 Spell, assume 11% reduction achieved in 2015/2016 = 71 spells.

The expansion to the service is due to start 1/4/2015.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Scheme will be monitored via BCF Board and Delivery Group to ensure targets and objectives are met.

What are the key success factors for implementation of this scheme?

- Ensuring the required skilled workforce is available to provide the service
- Ensuring there are the required facilities available across the East Riding to allow the classes to take place
- Ensuring there is engagement from partners in terms of attendance and participation at regular steering groups
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>To reduce unnecessary paediatric asthma admissions to secondary care, optimise primary care management and promote self-care.</td>
</tr>
</tbody>
</table>

**What is the strategic objective of this scheme?**

To improve the care of children and young people suffering from asthma to reduce and prevent their attendance at A&E and/or admission to hospital. For those who require an unavoidable emergency admission, the programme will aim to reduce the average length of stay to bring it in line with the average for the top 5% of CCGs.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The scheme will target children and young people under 19 years to prevent (where possible) and reduce the number of unplanned admissions for asthma by providing a multi-faceted programme. This will include:

- Providing a multi-faceted programme to identify areas for development which will introduce and develop strategies to improve asthma control amongst under 19s and promote self-care
- Offering training in GP practices and to community health and pharmacy colleagues to improve asthma management
- Ensuring children and young people who have had an emergency admission for asthma receive excellent discharge and follow-up care and advice to reduce and prevent the need for further admissions

As part of the programme, the CCG will seek to promote the Asthma UK “Compare Your Care Pledge” to implement the relevant NICE Asthma Quality Standard (QS25) for children and young people aged under 19 years. It will also encourage an integrated package of care for patients.

The programme is based on the very successful Paediatric Asthma Project but adapted to meet the particular needs and circumstances of the East Riding of Yorkshire CCG area (see attached plan).

Reducing admissions for paediatric asthma is an issue on the risk register for East Riding CCG. Although the total savings for secondary care are lower than the cost of the programme, it is anticipated that the benefits to individual children and their families could be considerable including to their health and well-being, education and socially. Savings would also be made in primary care, medication costs, a reduction in GP appointments required etc.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

| Commissioners: East Riding CCG - GP, Senior Pharmacist, Lead Commissioner for Women and Children |
| East Riding of Yorkshire Council Public Health – to be determined |

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme: To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Nurses (Hull and East Yorkshire NHS Hospitals Trust)</td>
<td>Implement discharge pack including asthma action plan, follow up by asthma specialist nurse where required. Providing or supporting training to schools, day care settings etc</td>
</tr>
<tr>
<td>School Nurses (Humber NHS Foundation Trust)</td>
<td>Support school staff and pupils to enable good care and management in schools, increasing child / young person and parental confidence</td>
</tr>
<tr>
<td>Health Visitors (Humber NHS Foundation Trust)</td>
<td>Support children with asthma and parents to ensure understanding, compliance with treatment and good asthma management</td>
</tr>
<tr>
<td>GPs</td>
<td>Offer GP / nurse appointments within 48 hours of secondary care episode, ensure optimum medication provided and good care</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>Offer GP / nurse appointments within 48 hours of secondary care episode, check inhaler technique, annual asthma checks</td>
</tr>
<tr>
<td>Community Paediatric Nurses (Community Health Care Partnership)</td>
<td>Provide support to children / young people in the community with asthma as part of their complex needs</td>
</tr>
<tr>
<td>Education Welfare Officer (East Riding of Yorkshire Local Authority)</td>
<td>Work with schools to encourage and promote good, safe care and management of children / young people with asthma in school, including arranging / encouraging staff training, working with parents to ensure good attendance of their child etc.</td>
</tr>
<tr>
<td>Public Health (East Riding of Yorkshire Local Authority)</td>
<td>Promote non-smoking message, adoption of exercise, self-care etc</td>
</tr>
</tbody>
</table>
Pharmacies
Ensure patients know how to use medication, inhaler technique and advice; medicine review

Project Steering Group:
Membership – CCG GP, CCG Lead Commissioner of Women and Children, CSU Senior Pharmacist
First meeting - October 2014
Regularity of meetings – monthly
Role – to provide strategic direction and lead the project, oversight, ensure outcomes achieved

Project task and finish group
Membership – see above
First meeting – December 2014
Regularity of meetings – bi-monthly
Role – develop project plan and ensure its implementation

Project staff
To be appointed by April 2015
Role – to provide support to health, local authority and other colleagues to implement the project

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The programme is based in part on the Ealing children’s Asthma Project which led to a 40% reduction in admissions and a saving of £90k over a two year period (2010 – 2012). While the epidemiology and geography etc for the East Riding of Yorkshire CCG differs considerably from that of Ealing, there is considerable learning to be gained from their project. However the savings to be gained will be less due to the lower starting point in numbers of admissions involved. Therefore it was felt that a 20% reduction of admissions and 35% reduction in attendances at ED (but not admitted) would be more effective targets.

The programme will also promote the introduction of the NICE Asthma Quality Standard (QS25).

These two approaches should help to continue to reverse the increase in admissions and average length of stay in the East Riding of Yorkshire from a peak in 2012/13. It would also help to bring them more in line with the top 5% of admissions amongst CCGs.
**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£130,000 over two years (1 x band 7 FTE nurses, 0.5 x WTE band 3 administrator, training, resources, expanded commissioned primary care for paediatric asthma as required and other costs).

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Impact of the scheme on paediatric asthma admissions

<table>
<thead>
<tr>
<th>Impact on paediatric asthma admissions</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Impact of programme over two years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in number of admissions for paediatric asthma</td>
<td>109</td>
<td>142</td>
<td>111</td>
<td><strong>22 fewer admissions</strong></td>
</tr>
<tr>
<td>Reduction in the average length of admission by days to bring in line with top 5% of CCGs of 0.79 days per admission</td>
<td>0.9</td>
<td>1.17</td>
<td>0.92</td>
<td><strong>0.13 reduction in average length of stay</strong></td>
</tr>
<tr>
<td>Number of paediatric asthma attendances at ED not admitted</td>
<td>332</td>
<td>299</td>
<td>514</td>
<td><strong>82 fewer admissions from ED</strong></td>
</tr>
</tbody>
</table>

**Financial savings**

<table>
<thead>
<tr>
<th>Financial savings</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Financial savings of programme over two years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings in the cost of admissions for paediatric asthma</td>
<td>£76,798</td>
<td>£96,486</td>
<td>£77,080</td>
<td><strong>£15,416 saved</strong></td>
</tr>
<tr>
<td>Cost of paediatric asthma attendances at ED not admitted</td>
<td>£26,449</td>
<td>£25,067</td>
<td>£38,445</td>
<td><strong>£11,996 saved</strong></td>
</tr>
<tr>
<td>Total proposed savings</td>
<td></td>
<td></td>
<td></td>
<td><strong>£27,412</strong></td>
</tr>
</tbody>
</table>

- It is anticipated that there would be a reduction in the number of primary care appointments as a result of the project but it is not possible to quantify this due to the lack of availability of data.
Impact of other non-quantifiable evidence:
- Improved quality of care and quality of life of children and young people and their families
- The programme will also support reducing school absence, improving social well-being etc
Meeting NICE quality standards.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monitoring data, feedback to CCG board, GPs and other agencies and professionals involved in the project.

**What are the key success factors for implementation of this scheme?**

Interagency by-in across the CCG area from a wide range of agencies and professionals including GP practices, pharmacies, schools, childcare settings, social services (especially for Looked After Children) etc.

Critical factors for the successful implementation and delivery of the outcomes of the project include:

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma Nurses (Hull and East Yorkshire NHS Hospitals Trust)</strong></td>
<td>Implementing the discharge pack including asthma action plan, follow up by asthma specialist nurse where required. Providing or supporting training to schools, day care settings etc</td>
</tr>
<tr>
<td><strong>School Nurses (Humber NHS Foundation Trust)</strong></td>
<td>Supporting school staff and pupils to enable good care and management in schools, increasing child / young person and parental confidence</td>
</tr>
<tr>
<td><strong>Health Visitors (Humber NHS Foundation Trust)</strong></td>
<td>Supporting children with asthma and parents to ensure understanding, compliance with treatment and good asthma management</td>
</tr>
<tr>
<td><strong>GPs</strong></td>
<td>Offering GP / nurse appointments within 48 hours of secondary care episode, ensure optimum medication provided and good care</td>
</tr>
<tr>
<td><strong>Practice Nurses</strong></td>
<td>Offering GP / nurse appointments within 48 hours of secondary care episode, check inhaler technique, annual asthma</td>
</tr>
<tr>
<td>Role</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Community Paediatric Nurses (Community Health Care Partnership)</td>
<td>Providing support to children / young people in the community with asthma as part of their complex needs</td>
</tr>
<tr>
<td>Education Welfare Officer (East Riding of Yorkshire Local Authority)</td>
<td>Working with schools to encourage and promote good, safe care and management of children / young people with asthma in school, including arranging / encouraging staff training, working with parents to ensure good attendance of their child etc.</td>
</tr>
<tr>
<td>Public Health (East Riding of Yorkshire Local Authority)</td>
<td>Promoting non-smoking message, adoption of exercise, self-care etc through existing and new programmes</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>Ensuring patients know how to use medication, inhaler technique and advice; medicine review</td>
</tr>
</tbody>
</table>

7 Yorkshire and Humber Commissioning Support: East Riding of Yorkshire CCG Asthma data for children under 19 BI job ref. 2488 v5
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheme name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven day working pilot at Castle Hill Hospital (HEY facing)</td>
</tr>
</tbody>
</table>

What is the strategic objective of this scheme?

This strategic objective of the scheme is to support a seven day a week social work service, to assessment and discharge planning, in line with the measures and requirements of the Better Care Fund and the Care Act 2014.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

This twelve month scheme will establish 2 x Social Worker posts to work on the Castle Hill Hospital site, covering all 27 wards. These posts will be contracted to work a five day week, including Saturday and Sunday. The rationale for a five day contract would be to ensure handover and continuity within the existing team who currently work Monday to Friday. At the weekend the workers would prioritise those cases highlighted as ready for discharge at the daily Progress to Discharge List meetings from the Integrated Discharge Hub, whilst also initiating assessment requests, which currently only takes place Monday to Friday. These posts would form part of the existing hospital discharge team and ensure that patients from the East Riding are assessed and placed on the correct referral pathway at the earliest stage in their acute stay, whilst also providing a gate-keeping role in making sure that people who do not require hospital admission are redirected to the appropriate community services. This would support the delivery of strategic goals, including care closer to home, self-care and avoiding preventable admissions to hospital and long term care.

These workers will also act as a focal point for enquiries from the wards to expedite and resolve issues which may prevent weekend discharge. Having workers available over the weekend will provide a more responsive service to family members. The creation of these posts would provide a comprehensive discharge service over the weekend, in conjunction with the existing Integrated Hospital posts which have been established at Hull Royal for three years.

Creation of these posts would support integrated working with health colleagues, as they
move towards a seven day working model.

To support delivery of this service this scheme also includes the establishment of a 0.5 post within the East Riding Business Unit to contract and commission packages of care/residential placements over the weekend. Whilst supporting the proposed 2 Social Worker posts above, this commissioning post would also support the existing Integrated Hospital team posts, based on the Hull Royal site.

As these posts would be full time, working days would include the traditionally busier days at the end/ beginning of the week, which would further enhance the existing team and increase capacity whilst providing continuity and improving communication.

### The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

<table>
<thead>
<tr>
<th>Commissioners: East Riding of Yorkshire Clinical Commissioning Group</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme – To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Workers - East Riding of Yorkshire Council</td>
<td>Support timely discharges from acute hospitals through undertaking Social Care Assessments, setting up services, facilitating access to equipment and referrals to other services including Occupational Therapy Assessments.</td>
</tr>
</tbody>
</table>

### The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The move to a seven day working model is an expectation of the Care Act and Better Care Fund. As part of the new regulations on Transfers of Care from Hospital, assessment and discharge notifications will be issued over seven days. The NHS institute for Innovation and Improvement state in their quality and improvement tool for discharge planning: “Many hospitals still try to manage weekend capacity by discharging large numbers of patients on a Friday. Discharges then slow to a trickle until Monday morning (or often Monday afternoon). This is not the most effective strategy. It often takes several days for the mismatch between admissions and discharges, built up over the weekend, to resolve, with predictable consequences in terms of pressure on beds.”

(http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/discharge_planning.html)
The existing Integrated Hospital team model which currently operates over seven days has demonstrated significant benefits and expedited discharge over the weekend from A&E and the Acute Assessment Unit. As this service has evolved and awareness of a seven day model has become embedded in practice, their activity over the weekend have increased.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

To provide sufficient SW staffing and back office commissioning support for this pilot, the costs of the service will be as follows:

- 2 x Social Workers - £72,166
- 0.5 Commissioning & review officers- £11,386
- Equipment £ 3,000
- Travel £ 1,000

**Total Costs (in on-costs) £87,552 per annum**

Evidence from seven day working currently operated within Hull Royal Infirmary, has led to continued investment in seven day Social Worker presence in the A&E, AAU being sought to support other key acute hospitals, who support patients who are residents of the East Riding. It is assumed that this scheme will be at least cost neutral in terms of its financial cost, with a target to save at least 438 bed days. The pilot will be thoroughly evaluated and used to inform shaping of future seven day services across Health and Social Care. In addition to preventing admissions and supporting discharges, thus saving bed days, the team will also improve patient flow, patient experience and improve integrated working across health and social care.

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme would need to save 438 excess bed days to break even and we are confident that it would.

Anticipated outcomes include:

- To progress patient flow through the system.
- To minimise delayed discharge, whilst supporting good practice on discharge.
- Improved patient experience.
- Improves services to provide more responsive and patient centred care seven days a week.

It is hoped that this scheme will evidence the effectiveness of a seven day service, whilst starting to embed this service in existing discharge practice.
**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators, to be reported to the Clinical Commissioning Group on a monthly basis include:

- Number of patients seen/screened by Adult Social Care at Castle Hill Hospital
- Number of Adult Social Care facilitated discharges taking place at a weekend
- Reduction in the length of time between referral and discharge plan

Additional indicators also include:

- Number of Section 2’s allocated/assessments completed.
- Lengths of time between referral, assessment completed and discharge plan.
- Reduction in acute bed stays.
- Reduction in delayed transfers of care.
- Reduction in Sit-Rep reportable delayed transfers.
- Reduced bed occupancy levels in Castle Hill Hospital
- Patient/service user experience feedback survey.

Involvement in Multi-disciplinary Team meetings within the Discharge Team will also help to identify what is working and not working within the teams.

**What are the key success factors for implementation of this scheme?**

Promoting discharge over seven days will increase acute bed capacity by decreasing length of stay. Current practice and culture accepts a five day working response (covering only 5/7ths (71%) of the week). Discharge planning will be continuous rather than the existing practice which stops/starts for the weekend. This means that potentially patients, whose discharge could be progressed over the weekend, have to wait until Monday to be discharged, resulting in a loss of two bed days. The social work team currently receives an average of 164 requests for assessment per month which could potentially be progressed over seven days.

- Timely access to assessment and discharge planning and access to seven day a week social care services is key for supporting timely discharges and preventing unnecessary admissions to hospitals.
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheme name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Hospital Team (Scarborough Hospital, York Teaching Trust)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the strategic objective of this scheme?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through improved access to seven day a week access to Social Care Assessments within the hospital setting, it is anticipated that this scheme will improve patient flow through acute hospital beds, reduce length of stay and also prevent unnecessary admissions (through in-reach into the Emergency Department).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overview of the scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide a brief description of what you are proposing to do including:</td>
</tr>
<tr>
<td>- What is the model of care and support?</td>
</tr>
<tr>
<td>- Which patient cohorts are being targeted?</td>
</tr>
</tbody>
</table>

This ERYC scheme is for East Riding CCG the creation of 1.5 dedicated Social Worker posts based in Scarborough Hospital. These posts will support 7 day working, in line with the requirements of the Better Care Fund and the Care Act 2014.

These posts would be contracted to work over the seven day period. At weekends, these workers will also act as a focal point for enquiries from the wards to expedite and resolve issues which may prevent weekend discharge. Having workers available over the weekend will provide a more responsive service to family members.

These posts would form part of the discharge team and ensure that patients from the East Riding are assessed and placed on the correct referral pathway at an early stage in their acute stay. In addition it is hoped that these workers will in-reach to A&E, providing an assessment function but also providing a gate-keeping role in making sure that people who do not require hospital admission are redirected to the appropriate community services. This would support the delivery of strategic goals, including care closer to home, self-care and avoiding preventable admissions to hospital and long term care.

The scheme is aimed at all adult residents in the ER, aged 18 and over, who are either on a base ward within Scarborough Hospital or attend the Emergency Department.
Part 1

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: East Riding of Yorkshire Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme – To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Workers - East Riding of Yorkshire Council</td>
<td>Support timely discharges from acute hospitals through undertaking Social Care Assessments, setting up services, facilitating access to equipment and referrals to other services including Occupational Therapy Assessments.</td>
</tr>
</tbody>
</table>

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This application is supported by evidence from the “Perfect week” initiative, which took place at Scarborough Hospital 19-26th May. Our evaluation of this week showed that 30 East Riding patients were seen on the Scarborough site, which led to 7 new assessments, 3 re-starts of existing services and some signposting to other sites, including the Wolds Unit for palliative care.

Evaluation and feedback from York Teaching Hospital Trust was extremely positive, and the presence of social care on site, acting as part of a multi-disciplinary discharge team, was seen as a key contributor to the success of the project. All parties found that having an ERYC Social Worker on site provided an immediacy and ability to problem solve, reducing unnecessary delays waiting for completion of Section 2 requests, allocation and travelling to site. Currently locality teams in Bridlington and Driffield send staff in response to Section 2 requests, which does not give the hospital a consistent presence and can add additional bed days whilst establishing patients’ suitability/eligibility for social care.

Data from the “Perfect Week”, where we had a worker based on site, showed a considerable increase in performance, as the whole health and social care team pulled together. This included:

The 95% target in ED was achieved during the Perfect Week with 95.01% despite an increase in patient activity (3% up on previous week). There were 33% less breaches and the 4 hour target of 95% was met for only the second week since March 2014.

The overall average length of stay for spells of care ending in SGH general and acute wards fell from 4.68 (6 weeks prior to ‘Perfect Week’) to 4.33 days; a 7.5%
reduction.

The number of patient outliers reduced steadily throughout the week from 30 to 2. The number of patients ready to move to their next destination but experiencing a delay also reduced steadily throughout the week from 30 at the beginning of the week to 7 at the end of the week.

Bed availability improved throughout the week even though non-elective admissions were higher than in previous weeks (13% up on the average of the previous three weeks).

To support delivery of this service this proposal also includes a request to establish a 0.5 post within the East Riding Business Unit to contract and commission packages of care/residential placements over the weekend.

Evidence from York Trust shows that 30% of people attending A&E in Scarborough come from the East Riding. Additionally, evaluation from the RATS project which took place during the winter period of 2013-2014 highlighted difficulties establishing the status of East Riding patients, making contact with the correct teams and having local knowledge of the support available. Having a dedicated worker on duty seven days a week, would go a long way to eradicating this problem.

### Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 x Social Workers</td>
<td>£53,590</td>
</tr>
<tr>
<td>0.5 Commissioning &amp; review officers</td>
<td>£11,386</td>
</tr>
<tr>
<td>Equipment</td>
<td>£ 3,000</td>
</tr>
<tr>
<td>Travel</td>
<td>£ 1,000</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td><strong>£68,976</strong></td>
</tr>
</tbody>
</table>

Evidence to support the development of seven day working at Scarborough Hospital is based on the work undertaken as part of the perfect week initiative. The perfect week initiative took place in May 2014 and evidence is included in the evidence base box above. The pilot will be thoroughly evaluated and used to inform shaping of future seven day services across Health and Social Care. It is assumed that this scheme will be at least cost neutral in terms of its financial cost, with a target to save at least 345 bed days. In addition to preventing admissions and supporting discharges, thus saving bed days, the team will also improve patient flow, patient experience and improve integrated working across health and social care.
### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme would need to save 345 excess bed days to break even and we are confident that it would.

Anticipated outcomes include:

- To progress patient flow through the system.
- To minimise delayed discharge, whilst supporting good practice on discharge.
- Improved patient experience.
- Improves services to provide more responsive and patient centred care seven days a week.

It is hoped that this scheme will evidence the effectiveness of a seven day service, whilst starting to embed this service in existing discharge practice.

### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators, to be reported to the Clinical Commissioning Group on a monthly basis include:

- Number of patients seen/screened by Adult Social Care at Scarborough Hospital (including ED). Target of 30+ per week.
- Number of Adult Social Care facilitated discharges taking place at a weekend
- Facilitated transfers directly from Scarborough Hospital (Target of 5 per week)

Additional indicators also include:

- Number of Section 2’s allocated/assessments completed.
- Lengths of time between referral, assessment completed and discharge plan.
- Reduction in acute bed stays.
- Reduction in delayed transfers of care.
- Reduction in Sit- Rep reportable delayed transfers.
- Reduced occupancy levels in Scarborough/ Bridlington Hospitals.
- Improved escalation levels for Scarborough Hospital and East Riding Health and Social Care community.
- Patient/service user experience feedback survey.

Involvement in Multi-disciplinary Team meetings within the Discharge Team will also help to identify what is working and not working within the teams.
### What are the key success factors for implementation of this scheme?

Promoting discharge over seven days will increase acute bed capacity by decreasing length of stay. Current practice and culture accepts a five day working response (covering only 5/7ths (71%) of the week). Discharge planning will be continuous rather than the existing practice which stops/starts for the weekend. This means that potentially patients, whose discharge could be progressed over the weekend, have to wait until Monday to be discharged, resulting in a loss of two bed days. The social work team can then progress timely discharges over seven days.
## ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheme name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge support and reablement</td>
</tr>
</tbody>
</table>

### What is the strategic objective of this scheme?

To facilitate improved through flow from acute beds into reablement services, by investment in a dedicated Occupational Therapist/Occupational Therapy Assistant focussed entirely on discharge support and reablement, with improved access to modular ramps and steps.

### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The East Riding of Yorkshire Council scheme is for additional investment into Social Care to support the move towards a discharge to assess model, by the creation of two one year Occupational Therapy posts (an OT and an OT Assistant), with access to modular ramps, a range of specialist equipment and our existing reablement services. The scheme is set to run for a period of one year and offers a seven day a week service from 9am to 5pm.

The scheme also includes the purchase of five modular ramps and steps, to expedite hospital discharges. Currently, ramps are provided via a disabled facilities grant, which are means tested and can take in excess of 12 weeks to provide (as an urgent referral) and up to two years for low priority referral. These ramps and steps are recyclable and therefore can be provided for a temporary period, until the grant process is completed. Alternatively, these can also be used in cases where mobility issues are temporary and access to long term use of ramps/steps will not be required. Ramps/steps can be provided within 24 hours of a site visit, with the cost of installing and refurbishing these on an ongoing basis, being funded from the ERYC Disability Resource Team Budget.

The scheme will target ER residents, aged 18 and over, who need access to an OT assessment, equipment, ramps/steps and/or reablement services.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: East Riding of Yorkshire Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme – To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Occupational Therapy Services - East Riding of Yorkshire Council</td>
<td>Support timely discharges from acute hospitals through undertaking Occupational Therapy Assessments, triaging through to a plethora of re-ablement services, providing seven day a week support to re-ablement beds, facilitating access to equipment e.g. modular ramps and referrals to other services including Care Management and third sector.</td>
</tr>
</tbody>
</table>

The evidence base
Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes

Evidence from SCIE longitudinal studies suggest that timely access to reablement services is key for supporting timely discharges, preventing unnecessary admissions to hospitals and maximising independence. The scheme is expected to reduce issues around unnecessary delays from hospital due to access/egress to patients properties and to support people to regain/maximise independence and thus delay/prevent admissions to long term care.

Occupational therapists core skills are transferable between primary and secondary care, therefore increasing the capacity in one contributes the capacity of the other. Occupational Therapist in the Acute Sector no longer has capacity to carry out home assessment, visits which are often key to the sustainability of a discharge plan. Rapid access to Occupational Therapists, as part of a range of reablement services is key to establishing improved pathways for high intensity users of Emergency Departments e.g. frail elderly. Access to temporary modular ramps is also key to enabling safe hospital discharges, with key issues/benefits being:

- Following surgery, access to ramps is frequently needed for a short duration of time.
- There are waiting lists and processes associated with applying for Disabled Facilities Grants
- Modular ramps are reusable and can be fabricated to meet a number of variations in property access needs, within a 24 hour period.
- Changes to the timeliness in which wheelchairs are provided has meant that patients often receive their wheelchair well in advance of the provision of a ramp. In such circumstances, a modular ramp can be used as a temporary solution.

This scheme will expedite hospital discharges, support timely access to OT assessments and aids and adaptations. This will also form a key element of the move towards a discharge to assess model, as demonstrated as good practice in the Warwickshire area. Access to such services is key to ensuring sustainable discharges, reducing the need for on-going services and reducing the risk of admission to long term care.

This scheme will aim to deliver a considerable reduction in permanent admission of older people to residential and nursing homes, as part of our range of reablement services.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

<table>
<thead>
<tr>
<th>Option 2 – A seven day service (9 am to 5 pm)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td><strong>Modular ramps/steps</strong></td>
</tr>
<tr>
<td><strong>Equipment/travel</strong></td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
</tr>
</tbody>
</table>

Ongoing fitting, removing, storage and recycling costs will be borne by the ERYC Disability Resource Team.

Evidence to support the development of seven day Occupational Therapy working to support re-ablement services across the East Riding is based largely on the SCIE longitudinal studies, as detail in the evidence section above. The pilot will be thoroughly evaluated and used to inform shaping of future seven day services across Health and Social Care. It is assumed that this scheme will be at least cost neutral in terms of its financial cost, with a target to save at least 566 bed days. In addition to preventing admissions and supporting discharges, thus saving bed days, the team will also improve patient flow, patient experience and improve integrated working across health and social care.
**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme would need to save 566 excess bed days to break even and we are confident that it would.

Anticipated outcomes include:
- To carry out an Occupational Therapy assessment and treatment/outcome plan with patients/service users referred into the service
- To maximise a services users potential to remain living in their own home, by maximising their independence in activities of daily living and delaying/preventing the need for residential care.
- To facilitate safe/timely discharge planning, including the provision of equipment and minor adaptations.
- Provide rapid access to home assessment visits and ramps and steps to enable discharge from hospital or reablement services or prevent an unnecessary admission to hospital/care.

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators, to be reported to the Clinical Commissioning Group on a monthly basis include:

- Increased usage of reablement beds by 50%
- Increased referrals to the Short Term Assessment and Reablement Service by 10%

Additional indicators also include:

- Increase referrals to the Practical Home Support Service by 20%
- Usage/deployment of modular ramps/steps to prevent admissions
- Usage/deployment of modular ramps/steps to support discharges from acute hospitals
- High levels of patient/customer feedback

**What are the key success factors for implementation of this scheme?**

- Facilitating discharges over seven days a week will increase acute bed capacity by decreasing length of stay.
- Preventing admissions to hospital through access to 7 day a week equipment and assessment services
- Improving/maintaining independence of individuals in re-ablement services through the provision of Occupational Therapy Assessments and Support
- Facilitating access to other health, social care and third sector services
- Furthering the integration agenda, across all community, acute and local authority Occupational Therapy Services.
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

**Scheme ref no.**

10

**Scheme name**

Time to Think beds – HEY facing

**What is the strategic objective of this scheme?**

The scheme is for the creation of four “Time to Think Beds”. The aim of this scheme is to increase acute bed capacity by allowing the assessment and sourcing of a residential placement or care package to take place away from the acute setting. The use of these beds will be to promote independence and facilitate individuals to return home where possible, with the appropriate support, avoiding premature admission into residential care.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Commissioning of these beds would be a move towards a Discharge to Assess model, which has successfully been implemented in Warwickshire, Sunderland, Doncaster and Sheffield. These beds would fit alongside the existing provision provided by Community Hospitals and Reablement Units to provide a suite of options for discharge.

Evidence from areas adopting the Discharge to Assess model shows significant impact upon key indicators including delayed transfers of care, premature admission to residential care, whilst maintaining/increasing levels of independence and improving patient experience.

The beds will be used for individuals who are:

- MDT fit and over the acute phase of their illness and safe to be discharged into the care of a GP.
- Have been in hospital for some time and need a staged return home.
- Want to return home but Social Care still needs to establish the level of care needed or in cases where there are delays in setting up packages of care.
- Considering their choice of residential care.

Initially these beds will be spot purchased in residential and nursing settings to
enable timely mobilisation, once funding is in place. Spot purchasing beds meets the local authority requirement to provide a statutory right of choice, and enables a wider geographical spread to reflect the East Riding patient population. This method also provides flexibility in respect of sourcing beds based on the needs of the individual, e.g., nursing, residential, dementia, and in terms of occupancy levels, e.g., if four beds not used constantly, funding would be available if five beds needed for a given period.

The beds will be provided at no cost to each individual for a maximum of six weeks, which is a reasonable timescale for assessment and sourcing of services. This will be communicated in writing to each individual. Adult services staff will actively continue to work with individuals in these beds to progress their discharge.

To support delivery of this service, this proposal also includes a request to establish a 0.5 post within the East Riding Business Unit to contract and commission the “Time to Think Beds.” The Business Unit will also closely monitor the usage and provide this information on an ongoing basis to the Hospital Social Work Team.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The East Riding of Yorkshire Clinical Commissioning Group are the commissioners, the East Riding of Yorkshire Council are the procuring organisation, and the service will be delivered by Independent Care Home providers across the East Riding.

**The evidence base**
Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes

Evidence from areas adopting a Discharge to Assess model show that this model is effective and has:

- significantly reduced the numbers of delayed transfers of care in these areas.
- saved significant numbers of acute bed days, when set against the cost of funding the placements.
- although on a larger scale - Doncaster reported in 2012-2013 a number of 3754 acute bed days saved.

Utilising Time to Think Beds, as phase one of a discharge to assess model, will increase bed capacity within the acute sector. Even with the associated problems of sustainability (releasing monies from the acute sector), the improvement in patient experience, choice, and reductions in premature admissions to residential care, make it a true patient centred, independence supporting option.

- Analysis of East Riding patients from the HEY hospitals notified as a delayed transfer of care over the six-month period from January 2014-June 2014 show that on average 109 bed days are lost per month waiting for the availability of
home care packages or residential care beds. This analysis showed an average of 26 patients per month was in an acute bed waiting for the sourcing of services.

- Hull CCG currently commission step down facilities and report that since mid-January 2014 to date there have been 81 transfers of care into those beds equating to 3.375 transfers per week.
- Doncaster reports a reduction of 152 placements into residential care from hospital between 2011/12 and 2012/13.

The beds will also have an impact on inter-site transfers, decanting etc, which is a known source of dissatisfaction for patients and causes further delays in hospital transfers.

Analysis of this pilot will determine whether there is a business case for the sustainability of this scheme.

**Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

To provide HEY facing Time to Think beds, the cost of the service will be as follows:

- 4 beds @ £500 per week = £2,000 per week
- 12x months will be £104,000
- 0.5 Commissioning & review officers - £ 12,386
- Equipment £  1,000

**A total of £117,386 per annum**

Evidence to support the development of time to think beds is based on a move towards a Discharge to Assess model, which has successfully been implemented in Warwickshire, Sunderland, Doncaster and Sheffield. The pilot will be thoroughly evaluated and used to inform shaping of future services across Health and Social Care. It is assumed that this scheme will be at least cost neutral in terms of its financial cost, with a target to save at least 587 bed days. In addition to supporting discharges, thus saving bed days, the team will also improve patient flow, patient experience and improve integrated working across health and social care.

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme would need to save 587 excess bed days to break even and we are confident that it would.

Anticipated outcomes include:
➢ To progress patient flow through the system.
➢ To minimise delayed discharge, whilst supporting good practice on discharge.
➢ Improved patient experience.

It is anticipated that this scheme will evidence the effectiveness of a seven day service, whilst starting to embed this service in existing discharge practice. This scheme will also support the existing work of the Integrated Hospital Team and the Discharge Hub and fit alongside the existing provision provided by Community Hospitals, Intermediate Care, Reablement Services and Adult Social Care to provide a suite of options for discharge.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators, to be reported to the Clinical Commissioning Group on a monthly basis include:

➢ Numbers of patients admitted to Time to Think beds
➢ Length of Stay in Time to Think beds
➢ Occupancy levels
➢ Reduction in delayed transfers of care, compared to the previous six months/year.

A raft of additional indicators are also being collated as part of the scheme which include:

➢ Collation and analysis of the destination alternatives with associated costs for patients who utilise the Time to Think Beds.
➢ Reduction in admissions into long term care.
➢ Reduction in Sit- Rep reportable delayed transfers.
➢ Reduced occupancy levels in HEY Hospitals.
➢ Improved escalation levels for HEY, ERYC and the Hull and East Riding Health and Social Care community.

What are the key success factors for implementation of this scheme?

Offering free time to think beds across the ER, seven days a week, will potentially increase acute bed capacity by decreasing length of stay. Timely access to these beds will also enable Social Care to establish the level of care needed, to “bridge the gap” where there a delays in setting up packages of care and to give patients “time to think” in cases where they are considering their options or choice of residential care home.

Key success factors include:

➢ Appropriate location and timely availability of beds
➢ Development of a service, which does not automatically lead on to long term residential care
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>Time to Think beds – Scarborough facing</td>
</tr>
<tr>
<td>What is the strategic objective of this scheme?</td>
<td>The scheme is for the creation of three “Time to Think Beds”. The aim of this scheme is to increase acute bed capacity by allowing the assessment and sourcing of a residential placement or care package to take place away from the acute setting. The use of these beds will be to promote independence and facilitate individuals to return home where possible, with the appropriate support, avoiding premature admission into residential care.</td>
</tr>
</tbody>
</table>
| Overview of the scheme | Please provide a brief description of what you are proposing to do including:  
- What is the model of care and support?  
- Which patient cohorts are being targeted? |
| Commissioning of these beds would be a move towards a Discharge to Assess model, which has successfully been implemented in Warwickshire, Sunderland, Doncaster and Sheffield. These beds would fit alongside the existing provision provided by Community Hospitals and Reablement Units to provide a suite of options for discharge. |
| Evidence from areas adopting the Discharge to Assess model is that it has significant impact upon key indicators including delayed transfers of care, premature admission to residential care, whilst maintaining/increasing levels of independence and improving patient experience. |
| The beds will be used for individuals who are:  
- MDT fit and over the acute phase of their illness and safe to be discharged into the care of a GP.  
- Have been in hospital for some time and need a staged return home.  
- Want to return home but Social Care still need to establish the level of care needed or in cases where there are delays in setting up packages of care.  
- Considering their choice of residential care. |
| Initially these beds will be spot purchased in residential and nursing settings to enable timely mobilisation, once funding is in place. Spot purchasing beds meets the local |
authority requirement to provide a statutory right of choice, and enables a wider
geographical spread to reflect the East Riding patient population. This method also
provides flexibility in respect of sourcing beds based on the needs of the individual, e.g.
nursing, residential, dementia and in terms of occupancy levels e.g. if four beds not used
constantly, funding would be available if five beds needed for a given period.

The beds will be provided at no cost to each individual for a maximum of six weeks,
which is a reasonable timescale for assessment and sourcing of services. This will be
communicated in writing to each individual. Adult services staff will actively continue to
work with individuals in these beds to progress their discharge.

To support delivery of this service this proposal also includes a request to establish a 0.5
post within the East Riding Business Unit to contract and commission the “Time to Think
Beds”. The Business Unit will also closely monitor the usage and provide this information
on an ongoing basis to the Hospital Social Work Team.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and
providers involved

The East Riding of Yorkshire Clinical Commissioning Group are the commissioners, the
East Riding of Yorkshire Council are the procuring organisation and the service will be
delivered by Independent Care Home providers across the East Riding.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence from areas adopting a Discharge to Assess model show that this model is
effective and has:

- significantly reduced the numbers of delayed transfers of care in these areas.
- saved significant numbers of acute bed days, when set against the cost of funding the
  placements.
- although on a larger scale-Doncaster reported in 2012-2013 a number of 3754 acute
  bed days saved.

Utilising Time to Think Beds, as phase one of a discharge to assess model, will increase
bed capacity within the acute sector. Even with the associated problems of sustainability
(releasing monies from the acute sector), the improvement in patient experience, choice
and reductions in premature admissions to residential care, make it a true patient
centred, independence supporting option.

- Analysis of East Riding patients from the HEY hospitals notified as a delayed transfer
  of care over the six month period from January 2014-June 2014 show that on average
  109 bed days are lost per month waiting for the availability of home care packages or
  residential care beds. This analysis showed an average of 26 patients per month was
  in an acute bed waiting for the sourcing of services.
- Hull CCG currently commission step down facilities and report that since mid-January 2014 to date there have been 81 transfers of care into those beds equating to 3.375 transfers per week.
- Doncaster reports a reduction of 152 placements into residential care from hospital between 2011/12 and 2012/13.

The beds will also have an impact on inter-site transfers, decanting etc, which is a known source of dissatisfaction for patients and causes further delays in hospital transfers.

Analysis of this pilot will determine whether there is a business case for the sustainability of this scheme.

### Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 beds @ £500 per week</td>
<td>£1,500 per week</td>
</tr>
<tr>
<td>12 x months will be</td>
<td>£ 78,000</td>
</tr>
<tr>
<td>0.5 Commissioning &amp; review officers -</td>
<td>£ 11,386</td>
</tr>
</tbody>
</table>

**A total of £89,386 per annum**

Evidence to support the development of time to think beds is based on a move towards a Discharge to Assess model, which has successfully been implemented in Warwickshire, Sunderland, Doncaster and Sheffield. The pilot will be thoroughly evaluated and used to inform shaping of future services across Health and Social Care. It is assumed that this scheme will be at least cost neutral in terms of its financial cost, with a target to save at least 457 bed days. In addition to supporting discharges, thus saving bed days, the team will also improve patient flow, patient experience and improve integrated working across health and social care.

### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To break even the scheme would need to save 457 excess bed days and we are confident that it would.

Anticipated outcomes include:

- To progress patient flow through the system.
- To minimise delayed discharge, whilst supporting good practice on discharge.
- Improved patient experience.
- Reduction in delayed transfers of care, compared to the previous six months/year.
It is hoped that this scheme will evidence the effectiveness of a seven day service, whilst starting to embed this service in existing discharge practice. This scheme will also support the existing work of the Integrated Hospital Team and the Discharge Hub and fit alongside the existing provision provided by Community Hospitals, Intermediate Care, Reablement Services and Adult Social Care to provide a suite of options for discharge.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators, to be reported to the Clinical Commissioning Group on a monthly basis include:

- Numbers of patients admitted to Time to Think beds
- Length of Stay in Time to Think beds
- Occupancy levels

A raft of additional indicators are also being collated as part of the scheme which include:

- Collation and analysis of the destination alternatives with associated costs for patients who utilise the Time to Think Beds.
- Reduction in admissions into long term care.
- Reduction in Sit- Rep reportable delayed transfers.
- Reduced occupancy levels in HEY Hospitals.
- Improved escalation levels for HEY, ERYC and the Hull and East Riding Health and Social Care community.

What are the key success factors for implementation of this scheme?

Offering free Time to Think beds across the ER, seven days a week, will potentially increase acute bed capacity by decreasing length of stay. Timely access to these beds will also enable Social Care to establish the level of care needed, to “bridge the gap” where there a delays in setting up packages of care and to give patients “time to think” in cases where they are considering their options or choice of residential care home.

Key success factors include:

- Appropriate location and timely availability of beds
- Development of a service, which does not automatically lead on to long term residential care
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>Practical Home Support Service (PHS)</td>
</tr>
<tr>
<td>What is the strategic objective of this scheme?</td>
<td>To avoid delayed discharges from acute hospitals, based on the need to ensure that individuals are safe, reassured and have access to basic support.</td>
</tr>
</tbody>
</table>

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The PHS Service operates 24 hours a day, 7 days a week to provide practical support to prevent unnecessary admissions to hospital and support timely discharges for a period of up to 72 hours.

The short-term PHS Service operates for up to 72 hours to undertake basic tasks to support someone at home e.g. ensuring that their heating is on, undertaking shopping, setting a person back home, providing reassurance etc. The team also have access to provide 24/7 access to lifeline telecare installations, pending full telecare assessments and can also access small items of equipment such as foldable commodes etc. Joint working with the Yorkshire Ambulance Service (YAS) has resulted in the creation of a referral pathway to the PHS. This supports referrals from paramedics, whilst responding to emergency calls which do not require admission to hospital, but do require further intervention to provide reassurance and support to enable them to remain at home.

Reablement services are available to all residents of the ER aged 18 years and over to support discharges from acute hospitals or to prevent admissions to hospitals.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The East Riding of Yorkshire Clinical Commissioning Group are the commissioners and the East Riding of Yorkshire Council Business Management Unit are the providers of the service.
Commissioners: East Riding of Yorkshire Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme – To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Practical Home Support Services 24/7 - East Riding of Yorkshire Council</td>
<td>Support timely discharges from acute hospitals and prevent unnecessary admissions through the provision of basic levels of support (not personal care) e.g. putting on the heating, making a drink, providing reassurance, ensuring food is available and referral onto other Council, health and third sector services, as required.</td>
</tr>
</tbody>
</table>

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The design of the service is based on a plethora of evidence of unmet need from across Health and Social Care Services, including YAS, GP’s, Emergency Duty Teams, Care Management Teams, care providers, neighbours and families.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

To provide a level of supervisory/administrative staffing to support the running and performance monitoring of the 24/7 Practical Home Support Service across the East Riding. The cost of the service is as follows:

1 Senior Care Officer £ 29,261
20 hours Community Responder £ 9,829
Travel and office costs £ 4,910

A total of £ 44,000 per annum (invested in 2014/2015)
Evidence to support the continuation of Practical Home Support has been developed over a number of years to fill identified gaps and unmet needs from across Health and Social Care Services. PHS provides monitoring information on a monthly basis. In addition to provide a key element of systems to support discharges and prevent admissions, the team also improve patient/service user experience and improve integrated working across health and social care.

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Impact of the scheme is measured in terms of:

- Numbers of people referred to PHS
- Response times within two hours of receiving a referral
- Referrals onto other health and social care services
- Referrals onto voluntary sector services
- Numbers of supported discharges.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance against key indicators will be submitted to the ERYCCG on a monthly basis and discussed as part of the range of schemes which form part of the Better Care Fund.
<table>
<thead>
<tr>
<th>What are the key success factors for implementation of this scheme?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offering free reablement services across the ER, seven days a week, 24 hours a day, helps to support safe and timely discharges from acute beds and helps to prevent unnecessary admissions to hospital. Through the addition of minimal resources, this scheme utilises the ERYC existing Community Responder services to maximise use of staff skills, “down time” and provide access through a single point (the Driffield Hub). The service also facilitates access to other Council (e.g. re-ablement, Social Care, Occupational Therapy services), Health services and third sector prevention and support services.</td>
</tr>
</tbody>
</table>
### ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme name</td>
<td>Short Term Assessment and Reablement Service (STARS)</td>
</tr>
<tr>
<td><strong>What is the strategic objective of this scheme?</strong></td>
<td>To support people to maximise their recovery from illness, accident and/or hospital admission, maximise independence and prevent/delay admission to long term care.</td>
</tr>
</tbody>
</table>
| **Overview of the scheme** | Please provide a brief description of what you are proposing to do including:  
- What is the model of care and support?  
- Which patient cohorts are being targeted? |

The STARS service operates between 7 am and 10 pm, seven days a week. STARS provides a short-term service to support people to maximise their independence by learning or re-learning the skills necessary for daily living e.g. getting dressed, washed, making a meal. The service assesses individual needs, agrees a reablement support plan, provides practical and emotional support to improve confidence with daily living skills, works with individuals so that they can return home or remain at home and arranges delivery of small items of equipment to support independence.

Reablement services are available to all residents of the ER aged 18 years and over to support discharges from acute hospitals or to prevent admissions to hospitals.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: East Riding of Yorkshire Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Provider roles and organisation</th>
<th>Role in implementing the scheme – To support and enable colleagues to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Assessment and Reablement Service (STARS) - East Riding of Yorkshire Council</td>
<td>Support timely discharges from acute hospitals and prevent unnecessary admissions through the provision of a free re-ablement based domiciliary service, which improves independence through learning/relearning the skills for daily living. This is delivered through task focussed assessment, goal setting and review process to measure progress. Additionally the service identifies the need for ongoing services and then refers on to other Council, Health and Third Sector Services.</td>
</tr>
</tbody>
</table>

The evidence base
Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes

There is a raft of evidence around the success of assessment and reablement services included in various longitudinal studies, many of which are available on the Social Care Institute for Excellence (SCIE) website. Studies concluded that successful reablement can delay/reduce the need for ongoing access to Social Care services by as much as twelve to twenty-four months.

Offering free reablement services across the ER, seven days a week, helps to increase acute bed capacity by decreasing length of stay and preventing unnecessary admissions to hospital. Timely access to STARS also enables people’s Independence to be maximised before decisions are taken regarding ongoing care needs and/or considerations around long-term care. Key success factors are therefore reductions in packages of care post reablement and reductions in admissions to permanent residential care.
## Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

To provide a Short Term Assessment and Re-ablement Service 7 am to 10 pm, seven days a week. STARS provides a short-term service to support people to maximise their independence by learning or re-learning the skills necessary for daily living e.g. getting dressed, washed, making a meal. The cost of the service is as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>£1,366,000</td>
</tr>
<tr>
<td>Premises</td>
<td>£ 17,000</td>
</tr>
<tr>
<td>Travel</td>
<td>£ 308,000</td>
</tr>
<tr>
<td>Supplies and services</td>
<td>£  76,000</td>
</tr>
</tbody>
</table>

A total of £1,767,000 per annum - (Agreed for 2014/15 and 2015/16).

Evidence to support the provision of short term assessment and re-ablement services is supported by a raft of evidence around the success of assessment and reablement services included in various longitudinal studies, many of which are available on the Social Care Institute for Excellence (SCIE) website. The service provides a raft of performance information in terms of involvement, impact etc, which have supported the continuation of the services.

## Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved levels of independence (pre and post reablement) – currently measured using the Barthel scale.
- Reduced packages of care pre and post reablement
- Reductions in admissions to residential care

## Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance against key indicators will be submitted to the ERYCCG on a monthly basis and discussed as part of the range of schemes which form part of the Better Care Fund.
**What are the key success factors for implementation of this scheme?**

Support timely discharges from acute hospitals, prevent unnecessary admissions to hospital and permanent residential care, through the provision of a free seven day a week re-ablement based domiciliary care service, which improves independence through learning/relearning the skills for daily living. This is delivered through task focussed assessment, goal setting and review process to measure progress. Additionally the service identifies the need for ongoing services and then refers on to other Council, Health and Third Sector Services.
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>14</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Scheme name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care incorporating:</td>
</tr>
<tr>
<td>Pocklington Health and Social Care Hub</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the strategic objective of this scheme?</th>
</tr>
</thead>
<tbody>
<tr>
<td>By introducing ambulatory care models across both community and hospital settings we are intending to deliver:</td>
</tr>
<tr>
<td>2) an improved, integrated patient care pathway across both community and hospital care minimising duplication and unintended health and care consequences on the individual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overview of the scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide a brief description of what you are proposing to do including:</td>
</tr>
<tr>
<td>- What is the model of care and support?</td>
</tr>
<tr>
<td>- Which patient cohorts are being targeted?</td>
</tr>
</tbody>
</table>

The overall model involves a move from the traditional assumption that individuals need admitting to hospital in the event of a clinical exacerbation and that they need to stay there until all their assessments are undertaken. The model promotes:

- Earlier community intervention from a multi-agency team to assess the clinical and social need to be admitted to a hospital facility with the onus being to keep the individual at home wherever clinically appropriate with health and care packages of care and support being delivered within the individuals own home.

- Availability of rapid access clinics to provide hospital clinical review, advice and care planning.

- Support in the community to facilitate early discharge and discharge to assess i.e. where a patient is discharged home if clinically safe and other assessments are
undertaken within the patient’s own home e.g. physiotherapy).

- Dedicated patient care pathways within the acute setting for those patients who present at A&E with conditions that are clinically appropriate to be managed within an ambulatory facility and then discharged home with an appropriate health and care package and support.

The Pocklington Health and Social Care Hub

This Hub will ensure that frail, elderly and vulnerable people are supported and enabled to be as healthy, active and independent as possible in their own home for as long as possible and, where necessary, to support these individuals in a crisis and to ensure that there is a timely and efficient multi-agency response when a crisis occurs.

The key principles of the hub are:
- Person at the heart of the Hub;

- An MDT approach which will underpin the care support that is provided;

- Organisational communication and recognising each other’s pressures;

- Prioritisation of resources within statutory frameworks.

The Hub provides better, more coordinated care, closer to home and delivers:
- accessible and flexible services, via a single point of entry;

- seamless and holistic health and social care in the right place at the right time;

- the promotion of self-care of long term conditions; maximising people’s independence;

- support to live healthy and ‘full’ lives by reducing the need for intensive and costly interventions;

- support to people to retain or improve levels of independence via short term reablement.
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service is being commissioned by the Pocklington practice, the initial pilot period will be from Dec 14 through to Mar 15. The service will adapt and continue evolve becoming mainstream when final service model is defined.

The main providers of the service will comprise:
The Pocklington GP Practice
East Riding Social Care
District services provided by Humber Foundation Trust
Woldhaven Residential Home

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital (Avoiding unplanned admissions enhanced service: proactive case finding and care review for vulnerable people’ NHS England Gateway ref 01520 (April 2014).

Data suggests that many patients only attend A&E or are admitted to hospital as an emergency because of a lack of support in the community and that this is particularly true for those vulnerable patients who have frailty.

Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body’s physical and psychological reserves. The condition varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse ('Fit for Frailty: Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings' - Published by the British Geriatrics Society.)

Locally, across the East Riding, the age structure shows a relatively large number of older people, and population predictions suggest an overall population increase over the coming five years from 348,000 in 2012 to 364,300 by 2017 (ONS 2008 -based projections - May 2010), particularly among older people for the East Riding. Projections suggest that by 2017, in the East Riding, 77,000 people will be over 65 years old and 20,000 over 80. This will give rise to an increase in the number of people who will need to access community care for care and support to enable them to remain in their place of residence and avoid unnecessary hospital admissions.

Within these groups there is a significant sub set of individuals who have clinical conditions that can provide challenges in ensuring that they are able to understand and retain what can be complex information regarding the on-going management of their clinical conditions. For example it is predicated that the numbers of over 65s who are
living with a moderate or severe learning disability will increase from an estimated 215 in 2014 to an estimated 256 by 2020.

It is recognised nationally that patients with a long term condition (LTC) account for more than 50% of all GP appointments; 65% of all out patient appointments; over 70% of all inpatient bed days (2009 General Lifestyle Survey). This demand arises from the high level of individuals living with a LTC; in people of 65 years of age and over the number of multiple LTCs increases. A number of these long term conditions, especially when in combinations with other long term conditions and the impacts of the aging process, generate varying levels of frailty.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

**A summary of the scheme costs and savings is shown below, full details of costs savings and assumptions are provided in the Business case**

<table>
<thead>
<tr>
<th>Year ended 31 March</th>
<th>WTE</th>
<th>Band</th>
<th>FTE</th>
<th>Cost 2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent savings</td>
<td></td>
<td></td>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Non-recurrent savings</td>
<td></td>
<td></td>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Total savings</td>
<td></td>
<td></td>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Assessment Officer</td>
<td>1</td>
<td></td>
<td>4</td>
<td>38,384</td>
<td>38,384</td>
<td>38,384</td>
<td>38,384</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.50</td>
<td>6</td>
<td>1</td>
<td>42,231</td>
<td>7,039</td>
<td>21,116</td>
<td>21,116</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.50</td>
<td>6</td>
<td>1</td>
<td>42,231</td>
<td>7,039</td>
<td>21,116</td>
<td>21,116</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>0.75</td>
<td>8a</td>
<td>6</td>
<td>58,046</td>
<td>19,349</td>
<td>43,535</td>
<td>43,535</td>
</tr>
<tr>
<td>Admin Support</td>
<td>0.50</td>
<td>3</td>
<td></td>
<td>23,200</td>
<td>5,413</td>
<td>11,600</td>
<td>11,600</td>
</tr>
<tr>
<td>HCA</td>
<td>0.50</td>
<td>3</td>
<td></td>
<td>23,200</td>
<td>5,413</td>
<td>11,600</td>
<td>11,600</td>
</tr>
<tr>
<td></td>
<td>Doctor Time</td>
<td>2hrs/wk</td>
<td>£85 per hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
<td>---------</td>
<td>-------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Non Pay</td>
<td>Beds at Wold Haven (x3)</td>
<td></td>
<td></td>
<td>16,921</td>
<td>50,764</td>
<td>50,764</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Primary Care Elderly Funding</td>
<td></td>
<td></td>
<td>(36,068)</td>
<td>(76,000)</td>
<td>(76,000)</td>
<td></td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>43,793</strong></td>
<td><strong>130,955</strong></td>
<td><strong>130,955</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Net Savings</strong></td>
<td></td>
<td></td>
<td></td>
<td>(3212)</td>
<td>(9,210)</td>
<td>(9,210)</td>
<td></td>
</tr>
</tbody>
</table>

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Pocklington Health and Social Care Hub
The project will focus on the top 2% of the Practice population and will achieve success if it enables a reduction of 6% in unplanned admissions and a 75% reduction in excess bed days for those patients registered with the Pocklington Group Practice.

Pocklington Group Practice outturned at 1,220 non-elective admissions with York Teaching Hospitals NHS Foundation Trust in 2013-14. These admissions also resulted in 1,111 excess bed days (XBDs).
Based on the proposal described, the Hub is targeting a 6% reduction in non-elective admissions (73 spells) and a 75% reduction in XBDs (833 bed days).
The saving has been calculated using the average cost of the emergency tariff for the Practice at York Hospitals TFT of £1,900 reduced by the marginal rate adjustment of 30%, to £570.
A reduction in excess bed days has been calculated weighted between Emergency (less marginal rate) and Elective admissions to an average price of £96.20.

Total annual saving is:
Emergency admissions reduction 73 * £570 = £41,610
Excess bed days reduction 833 * £96.20 = £80,135
Total saving £121,745

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Activity information will be recorded and monitoring reports will be available on a monthly basis for the consideration of the Steering Group. The rate of unplanned admissions involving the 2% cohort will be monitored based on data to be supplied by the GP practices which will be benchmarked against those GP practices who are not in the locality but who are participating in the Unplanned admissions DES and have their own 2% cohorts.

Each GP practice in the locality will also undertake monthly MDT meetings examining all unplanned admissions involving vulnerable patients in the 2% cohort in order to assess whether the admission could have been prevented and what support would have made a difference to the patient.

**What are the key success factors for implementation of this scheme?**

Full engagement by the key service providers.
Identifying the necessary staffing capacity to create the Healthcare Co-ordinator role and to resource the other key functions (District nurses, therapists, OOH GPs, social care assessment officers).
Ensuring there is adequate funding to meet implementation and running costs.
ANNEX 1 – Detailed Scheme Description

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
</tr>
</tbody>
</table>

**Hospital Mental Health liaison Service in HEYHT Emergency Department**

**What is the strategic objective of this scheme?**

The hospital mental health liaison service at Hull and East Yorkshire Hospital Emergency Department (ED) will undertake mental health assessments and prevent subsequent unnecessary admissions from the emergency department by engaging with community services, mental health, social care and voluntary sector to ensure a safe and timely return home.

This service will contribute to the action plan developed as part of the Mental Health Crisis Care Concordat.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The aim of the service is to provide a mental health assessment earlier in a patient’s pathway and divert activity away from hospital admissions. Improving coordination of community responses to patient crisis, by establishing a short term wrap around care plan to enable a patient to resettled in their usual place of residence. The service will develop local engagement and work collaboratively with partner organisations in the community to facilitate this. The service will be required to undertake assessment within two hours of patients being referred to the team, where there is a suspected mental health problem. Where it is identified that there is no need for an acute hospital admission the team will take responsibility ensuring safe and timely return home. This support would be time limited, ideally a <4 hours, and never longer than 3 days.

The target group is any patient coming through the ambulatory care unit, Acute Medical Ward or Elderly Assessment Unit at Hull Royal, people who might have dementia and a mental health need but who would not benefit from an acute admission. The main objectives of the service are to:
- Improve patient experience and waiting times
- Ensure that patients receive high quality care by the most appropriate health care professional / stream
- Ensure patients receive continuity of care and a rapid discharge home from the Ambulatory Care Unit, Acute Medical Ward or Elderly Assessment Unit, via the development and implementation of shared care-pathways with community service providers

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Service will be commissioned within the *Prevention and Self-Care work stream* of the BCF and via the appropriate procurement channel. The Provider (Humber FT) currently operates a mental health liaison service within the hospital and additional investment would enable expansion of this provision in ED.

**The evidence base**

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are many estimates of the prevalence of dementia related admissions into adult acute hospital beds with the consensus settling around 4 in 10 of all older people - admissions having some type of dementia or 25% of all acute hospital admissions. It is also widely recognised that many of these people do not actually require admission to an acute bed and for those that are, physical health and psychological health outcomes are often poor.

The potential for a step change in how the system treats dementia was endorsed by an internal HEY audit of admissions of people with dementia which showed;

- 29% of people with dementia admitted had a diagnosis
- 80% of people with dementia were not known to MH services and therefore likely to be in receipt of minimal community based support
- Average length of stay was 28 days
- Of those in hospital:
  - 38% were awaiting social assessment
- 22% were awaiting care home placement
- 31% were actually being treated
- 28% of admissions were due to deteriorating mental health

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan (see table below)

**A mental health nurse to be based at Hull and East Yorkshire hospitals in the emergency department to support quicker assessment and discharge. Required three WTE band six mental health nurses at a total cost of £104,604.**

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1. A reduction in admissions to acute beds (HEYHT only). This will lead to increased opportunities to reduce unnecessary admissions for those patients with suspected MCI or Dementia
2. An increase in referrals for patients requiring more comprehensive early memory assessment which will contribute to increased detection rates
3. Improved continuity of care for those patients admitted to the 72 hour ward, due to continuous cover
4. Potential to improve patient’s experience of acute hospital services

Full year 86 admissions at £920 each = £79,120
Additional benefits (uncosted) include reduction in care home admissions from hospital

These savings are based on assumptions and specific coding. Other MH activity may also be reduced but not identified in these calculations.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance monitoring and evaluation with providers, with service users through patient stories and and via NEL admissions
### What are the key success factors for implementation of this scheme?

The provider is expected to contribute towards and adhere to National and Local performance targets

- 95% of patients will be assessed within 4 hours of referral
- Reduction in admission of patients with dementia or other mental health problems, where not clinically indicated
- Patient stories will be used to develop and inform service changes

### What is the strategic objective of this scheme?

The hospital mental health liaison service at Hull and East Yorkshire Hospital Emergency Department (ED) will undertake mental health assessments and prevent subsequent unnecessary admissions from the emergency department by engaging with community services, mental health, social care and voluntary sector to ensure a safe and timely return home.

This service will contribute to the action plan developed as part of the Mental Health Crisis Care Concordat.

### Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The aim of the service is to provide a mental health assessment earlier in a patient’s pathway and divert activity away from hospital admissions. Improving co-ordination of community responses to patient crisis, by establishing a short term wrap around care plan to enable a patient to resettle in their usual place of residence. The service will develop local engagement and work collaboratively with partner organisations in the community to facilitate this. The service will be required to undertake assessment within two hours of patients being referred to the team, where there is a suspected mental health problem. Where it is identified that there is no need for an acute hospital admission the team will take responsibility ensuring safe and timely return home. This support would be time limited, ideally a <4 hours, and never longer than 3 days

The target group is any patient coming through the ambulatory care unit, Acute Medical Ward or Elderly Assessment Unit at Hull Royal, people who might have dementia and a mental health need but who would not benefit from an acute
admission. The main objectives of the service are to:

- Improve patient experience and waiting times
- Ensure that patients receive high quality care by the most appropriate health care professional / stream
- Ensure patients receive continuity of care and a rapid discharge home from the Ambulatory Care Unit, Acute Medical Ward or Elderly Assessment Unit, via the development and implementation of shared care-pathways with community service providers

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Service will be commissioned within the *Prevention and Self-Care work stream* of the BCF and via the appropriate procurement channel. The Provider (Humber FT) currently operates a mental health liaison service within the hospital and additional investment would enable expansion of this provision in ED.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are many estimates of the prevalence of dementia related admissions into adult acute hospital beds with the consensus settling around 4 in 10 of all older people - admissions having some type of dementia or 25% of all acute hospital admissions. It is also widely recognised that many of these people do not actually require admission to an acute bed and for those that are, physical health and psychological health outcomes are often poor.

The potential for a step change in how the system treats dementia was endorsed by an internal HEY audit of admissions of people with dementia which showed:

- 29% of people with dementia admitted had a diagnosis
- 80% of people with dementia were not known to MH services and therefore likely to be in receipt of minimal community based support
- Average length of stay was 28 days
- Of those in hospital:
38% were awaiting social assessment
22% were awaiting care home placement
31% were actually being treated
28% of admissions were due to deteriorating mental health

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan (see table below)

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1) A reduction in admissions to acute beds (HEYHT only). This will lead to increased opportunities to reduce unnecessary admissions for those patients with suspected MCI or Dementia
2) An increase in referrals for patients requiring more comprehensive early memory assessment which will contribute to increased detection rates
3) Improved continuity of care for those patients admitted to the 72 hour ward, due to continuous cover
4) Potential to improve patient’s experience of acute hospital services

36 admissions at £1800 each = £64,800
Total potential annual saving = £64,800

Total Project 2 Target Saving - £27,000
Additional benefits (uncosted) include reduction in care home admissions from hospital

These savings are based on assumptions and specific coding. Other MH activity may also be reduced but not identified in these calculations.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance monitoring and evaluation with providers, with service users through patient stories and and via NEL admissions

What are the key success factors for implementation of this scheme?

The provider is expected to contribute towards and adhere to National and Local performance targets
• 95% of patients will be assessed within 4 hours of referral
- Reduction in admission of patients with dementia or other mental health problems, where not clinically indicated
- Patient stories will be used to develop and inform service changes.
ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<table>
<thead>
<tr>
<th>Name of Health &amp; Wellbeing Board</th>
<th>East Riding of Yorkshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider organisation</td>
<td>Hull &amp; East Yorkshire Hospitals NHS Trust</td>
</tr>
<tr>
<td>Name of Provider CEO</td>
<td>Chris Long</td>
</tr>
<tr>
<td>Signature (electronic or typed)</td>
<td>Chris Long</td>
</tr>
</tbody>
</table>

For HWB to populate:

<table>
<thead>
<tr>
<th>Total number of non-elective FFCEs in general &amp; acute</th>
<th>2013/14 Outturn</th>
<th>2014/15 Plan</th>
<th>2015/16 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20,979</td>
<td>20,824</td>
<td>20,623</td>
</tr>
<tr>
<td>14/15 Change compared to 13/14 outturn</td>
<td></td>
<td>-155</td>
<td></td>
</tr>
<tr>
<td>15/16 Change compared to planned 14/15 outturn</td>
<td></td>
<td></td>
<td>-201</td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 14-15?</td>
<td></td>
<td></td>
<td>205</td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 15-16?</td>
<td></td>
<td></td>
<td>776</td>
</tr>
</tbody>
</table>

For Provider to populate:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</td>
<td></td>
</tr>
<tr>
<td>3. Can you confirm that you have considered the resultant implications on services provided by your organisation?</td>
<td>Yes, we have worked closely with East Riding Health and Social Care partners on both the Better Care Fund projects and on our own internal transformation programme for our acute medical pathway. HEYHT is well represented on the Better Care Fund Programme Board. Similarly the CCG is both represented on our Medicine Transformation Board.</td>
</tr>
</tbody>
</table>
For 2015/16 we have well developed plans in hand which we expect to deliver a reduction of 500 East Riding patient non-elective admissions, compared to the current levels of activity.

There are a number of other projects in the East Riding Better Care Fund programme that are aiming to reduce non-elective admissions (although some are outside the HEYHY catchment eg the Goole Hub). These projects may deliver further reductions when fully scoped, tested and implemented, however they are not currently sufficiently well developed for us to assess their likely impact on non-elective admissions. In recognition of this the East Riding BCF plans have only anticipated reasonable modest impact for these schemes in 2015/15 which we find realistic.

The work to introduce ambulatory care and frailty assessment streams at the hospital as alternatives to non-elective admission is at an advanced stage of planning and the new model will go live in December 2014. We have updated our resilience plans to reflect the planned changes and in particular our surge and escalation arrangements in the advent of higher than expected levels of activity.

Hull and East Riding CCGs have, through the 2014/15 Resilience Monies provided non-recurrent resource to support the introduction of the new model.

The key risks identified are as follows:

1. Impact of the new models reduced by gaps in the medical workforce
2. Significantly higher levels of activity than predicted.
ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<table>
<thead>
<tr>
<th>Name of Health &amp; Wellbeing Board</th>
<th>East Riding of Yorkshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider organisation</td>
<td>North Lincolnshire and Goole NHS Foundation Trust</td>
</tr>
<tr>
<td>Name of Provider CEO</td>
<td></td>
</tr>
<tr>
<td>Signature (electronic or typed)</td>
<td></td>
</tr>
</tbody>
</table>

**For HWB to populate:**

<table>
<thead>
<tr>
<th>Total number of non-elective FFCEs in general &amp; acute</th>
<th>2013/14 Outturn</th>
<th>2014/15 Plan</th>
<th>2015/16 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/15 Change compared to 13/14 outturn</td>
<td>-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/16 Change compared to planned 14/15 outturn</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 14-15?</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 15-16?</td>
<td>61</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For Provider to populate:**

Despite a number of approaches to Northern Lincolnshire and Goole NHS Foundation Trust they have not responded and have concentrated their work on Better Care Fund Plans on those of their two main commissioning CCGs. We will continue to work with the Trust to ensure that there is alignment of plans. We will be including our planning assumptions during the forthcoming contract negotiation round to further reinforce the discussions to date.
ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<table>
<thead>
<tr>
<th>Name of Health &amp; Wellbeing Board</th>
<th>East Riding of Yorkshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider organisation</td>
<td>York Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Name of Provider CEO</td>
<td>York Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Signature (electronic or typed)</td>
<td>York Teaching Hospitals NHS Foundation Trust</td>
</tr>
</tbody>
</table>

For HWB to populate:

<table>
<thead>
<tr>
<th>Total number of non-elective FFCEs in general &amp; acute</th>
<th>2013/14 Outturn</th>
<th>7,463</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 Plan</td>
<td>7,408</td>
</tr>
<tr>
<td></td>
<td>2015/16 Plan</td>
<td>7,381</td>
</tr>
<tr>
<td>14/15 Change compared to 13/14 outturn</td>
<td>-55</td>
<td></td>
</tr>
<tr>
<td>15/16 Change compared to planned outturn</td>
<td>-26</td>
<td></td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 14-15?</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>How many non-elective admissions is the BCF planned to prevent in 15-16?</td>
<td>231</td>
<td></td>
</tr>
</tbody>
</table>

For Provider to populate:

Despite a number of approaches to York NHS Foundation Trust they have not responded and have concentrated their work on Better Care Fund Plans on those of their two main commissioning CCGs. We will continue to work with the Trust to ensure that there is alignment of plans. We will be including our planning assumptions during the forthcoming contract negotiation round to further reinforce the discussions to date.